

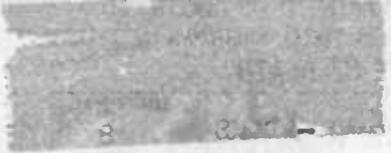
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
11013 CERTIFICATE OF DEATH 11021																				
1. DECEASED-NAME (Type or print)			First PEARL			Middle VIOLA			Last ADAMCZYK -ADAMS			2a. DATE OF DEATH 8 Month 1 Day 68 Year			2b. HOUR 10:20 PM					
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH August 8, 1923			6. AGE (In years lost birthday) 44 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.					
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md.								
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House work			12b. KIND OF BUSINESS OR INDUSTRY At Home											
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 808 S. Robinson St. #24.								
14. FATHER'S NAME Alexander Kwiatkowski			First Alexander			Middle Kwiatkowski			Last Kwiatkowski			15. MOTHER'S MAIDEN NAME Mary			First Mary			Last Latka		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Joseph W. Adams: 808 S. Robinson St. #24.			Address 808 S. Robinson St. #24.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY AND CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF <u>CARCINOMA OF LUNG AND DEHYDRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <u>163X</u>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>68</u> to <u>8/1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>Dr. F. Naeim</u>			DEGREE ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/1/68											
22d. PHYSICIAN'S NAME (Type) FARAMARZ NAEIM, MD.			22e. ADDRESS GBMC																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 8-5-68			23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cem.			23d. LOCATION (City or Town) (County) (State) German Hill Rd., Ba. Co.,											
24. FUNERAL DIRECTOR <u>Charles J. Geiler</u>			901 S. Conowing St. Balto., 21224, Md.			25a. REC'D BY REGISTRAR AUG 6 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

15011

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*Dr. F. H. ...*

*... 1958*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11014		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11022	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a. M
Albert				Aimutis	August 8, 1968		6:40 a.
3. SEX male		4. RACE white		5. DATE OF BIRTH May 2, 1915		6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Constantine Aimutis		15. MOTHER'S MAIDEN NAME Mary Matelis		13e. STREET AND NUMBER 673 West Fayette St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute, 4109 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic, Cardiovascular Ht. Dis. 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, Generalized, Senile 10 yrs. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from May 22, 19 39, to Aug. 8, 19 68, that (X) (we) last saw the deceased alive on Aug. 8, 19 68, and that in (my) (aX) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Anthony J. Young, M.D.		22c. DATE SIGNED 8-8-68		22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.			
22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



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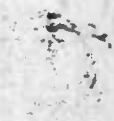
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11015										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11023																																																																					
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																																					
First JOSEPHINE										Middle T.										Last ALESSI										August										Month 14,										Day 1968.										Year										2-45A										M									
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH MARCH 9, 1887.										6. AGE (In years last birthday) 81										YRS.										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country) I ITALY										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE										Md.																																																	
10. CITY OR TOWN OF DEATH LUTHERVILLE										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8506 WESTFORD RD.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.										13b. COUNTY BALTIMORE										13c. CITY OR TOWN BALTO.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 1269 DEANWOOD ROAD																																																	
14. FATHER'S NAME First Philip										Middle TAGLIANETTI										Last Maria										15. MOTHER'S MAIDEN NAME First Parrella-Illaria										Middle Last																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 216-05-3809D										17. INFORMANT Dr Silvio A Alessi										Address 302 Gateswood Rd																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 arteriosclerotic heart disease										DUE TO, OR AS A CONSEQUENCE OF (b) Parkinsonism										DUE TO, OR AS A CONSEQUENCE OF (c) arthritis, multiple										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																														5 years																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																																					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																																					
22a. I certify that (I) (this hospital) attended the deceased from January, 1963, to August 17, 1968, that (I) (we) last saw the deceased alive on August 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																																									
22b. SIGNATURE E. J. Alessi M.D.										DEGREE ATTENDING PHYS.										<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.										22c. DATE SIGNED 8/14/68																																																											
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS 8506 Westford Rd Balto. Md																																																																															
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 8/17/68.										23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY										23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.																																																											
24. FUNERAL DIRECTOR LEONARD J. RUCK, INC. BALTO. MD. 21214										ADDRESS										25a. REC'D BY REGISTRAR AUG 16 1968										25b. REGISTRAR'S SIGNATURE James J. [Signature]																																																											

11333

RECEIVED

11333



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*Handwritten text, possibly a signature or address, located in the bottom center section of the document.*

*Handwritten text, possibly a signature or address, located at the bottom left of the document.*

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11016		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11024	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last HARRY K ALLEN			2a. DATE OF DEATH Month Day Year August 12 1968			2b. HOUR 8:10 P.M.	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH December 2, 1910		6. AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) TENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUMMIT NURSING H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DIET MAKER		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 31 DUNVEGAN RD.							
14. FATHER'S NAME First Middle Last LEWIS R. ALLEN			15. MOTHER'S MAIDEN NAME First Middle Last MARY C. SMITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 409-16-1286		17. INFORMANT Address Mrs. Linda C. Allen - 31 Dunvegan Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2381 DUE TO, OR AS A CONSEQUENCE OF BRAIN TUMOR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 10 Mos. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237x PNEUMONITIS							
19a. DATE OF OPERATION FEB 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TUMOR L. TEMPORO PARIETAL LOBE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 21, 1968, to Aug 12, 1968, that (I) (we) last saw the deceased alive on Aug 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John N. Snyder MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) JOHN N. SNYDER MD				22e. ADDRESS 6348 FREDERICK RD CATONSVILLE MD 21228			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-15-68		23c. NAME OF CEMETERY OR CREMATORY Lakewood Cem.		23d. LOCATION (City or Town) (County) (State) Covington County Md.	
24. FUNERAL DIRECTOR Address Foley-Corcoran B.F. Co. Catonsville Md.				25a. REC'D BY REGISTRAR DATE AUG 16 1968		25b. REGISTRAR'S SIGNATURE J. Charles J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1-68

11017										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11025																																																											
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																																																	
MARCELLUS										ALLEN										8 31 68										9:20 PM																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
MALE										WHITE										OCTOBER 1, 1885										82 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Mo.																																							
BALTIMORE, MD.										U.S.A.																				BALTIMORE																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
CATONSVILLE										HOUSE IN THE PINES										BALTIMORE TRANSIT																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																																							
MARYLAND										BALTIMORE A.A.										PASADENA										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										211 DRUM AV E. SOUTH																																							
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																																	
JOHN ALLEN																				PAULINE TRAPP																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
NO										213-10-0715										Marcellus W. Allen										Pasadena, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
										IMMEDIATE CAUSE (a) Cerebral Hemorrhage										1 hr.																																																											
										DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca of Cerebrum										1 hr.																																																											
										DUE TO, OR AS A CONSEQUENCE OF (c) Ca of Lung										5 hr.																																																											
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
										HOUR A.M. Month Day Year P.M. 19																																																																					
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																																																	
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																																																																															
22a. I certify that (I) (this hospital) attended the deceased from 7-31, 1968, to 8-31, 1968, that (I) (we) last saw the deceased alive on 8-31-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Wilmer K. Gallagher, M.D.										9-3-68																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Wilmer K. Gallagher, M.D.										6209 Frederick Ave. Baltimore, Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
BURIAL										9/4/68										GLEN HAVEN CEMETERY										GLEN BURNIE AA MD.																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
McCollig										130 E. Fort Ave. Baltimore, Md.										SEP 4 1968										Charles Judge																																																	

11082

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OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

DEPARTMENT OF THE ARMY

ADJUTANT GENERAL'S OFFICE

WASHINGTON, D. C.

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11082



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

11018										11026									
1. DECEASED-NAME (Type or Print) <b>SAMUEL IRVING ARONHIME</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>11</b> Year <b>1968</b>									
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>4-15-13</b>		6. AGE (In years) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>11</b> Year <b>1968</b>				2b. HOUR <b>10P</b>			
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>BALTIMORE</b>				Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSP</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4115 GROVELAND AVE</b>							
14. FATHER'S NAME First <b>Emanuel</b> Middle <b>Aronhime</b> Last <b>Bertha</b>				15. MOTHER'S MAIDEN NAME First <b>Bertha</b> Middle <b>Cowan</b> Last <b>Cowan</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>215-10-1875</b>				17. INFORMANT <b>A. S. Moskowitz - Nephew</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBDURAL HEMATOMA</b> <b>819.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CRANIO-CEREBRAL TRAUMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 WKS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8254</b>																			
19a. DATE OF OPERATION <b>6-29-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>SUBDURAL HEMATOMA</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <b>1 P.M. 6/29 1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>AUTO ACCIDENT</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>STREET</b>				21f. LOCATION Street or R.F.D. No. <b>BERRYMAN ROAD</b> City or Town <b>TOWSON</b> County <b>BALTO.</b> State <b>MD.</b>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>William A. Pilisbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>8-11-68</b>											
EXAMINER'S NAME (Type) <b>WILLIAM A. PILISBURY</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, P.O. box, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>8/12-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>V. of Md. School</b>											
24. FUNERAL DIRECTOR <b>Good Funeral Home, Bel Airville - 8-M</b>				ADDRESS <b>Baltimore, Md</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>											
				DATE <b>AUG 13 1968</b>				25b. REGISTRAR'S SIGNATURE											

11032

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11015

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11027

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR			
William		Amos		Bailey				8		17		1968		10 <sup>25</sup>		P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year			
Male	Can	5/28/38		30 YRS.		MONTHS		DAYS		8		17		1968		10 <sup>25</sup>			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH											
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
		St. Josephs Hosp		Warehouseman		Warehouse													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Maryland		Balto.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1205 Valleybrook Rd											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
Kenneth J. Bailey		Sr.						Mary E. Amos											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		9/14/60-9/12/66		212-36-0706		Mary Kibler 3648 Washington Blvd.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Multiple Injuries																			
8129																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
8164																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
				7 50 P.M. 8-17 19 68				head on collision of two automobiles											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
				Street				Md. Rte 165 north of Harford Co. Line Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						22b. DATE SIGNED							
Werner L. Spitz						M.D.						8-18-68							
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER						ADDRESS (Street, city, town, or county)							
Werner L. Spitz																			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				8/21/68				Lorraine Park Cemetery				Baltimore Maryland							
24. FUNERAL DIRECTOR								ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Ambrose Inc 1328 Sulphur Spring Rd.												AUG 26 1968				J. J. J. J.			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11020

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11028

1. DECEASED NAME (Type or Print)		First PEARL		Middle Y.		Last BAKER		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year Aug. 14 1968		2b. HOUR 7:30 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH [REDACTED]		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Aug. 14 1968	
7a. BIRTHPLACE (State or foreign country) ROMANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH Baltimore 21207		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6800 LIBERTY RD., APT. 411				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BALMORAL APTS. 6800 LIBERTY RD., APT. 411			
14. FATHER'S NAME First Middle Last HYMAN YAKOWITZ				15. MOTHER'S MAIDEN NAME First Middle Last TOBY BELZENBERG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-32-3749		17. INFORMANT ADDRESS MR. IRVIN KATZ, 4101 COLBY ROAD, #21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> none		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		D. D. Caples, M. D.		6 Hanover Rd.		Reisterstown, Md.		22b. DATE SIGNED 8-15-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-16-68		23c. NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Juge					

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*A. A. C. C.*

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363-0066 Released by the Papers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Dell</b>			First Middle Last <b>Barger</b>			2a. DATE OF DEATH Month Day Year <b>8-15-68</b>			2b. HOUR <b>10:30</b> M		
3. SEX <b>female</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>2-1-1891</b>			6. AGE (In years last birthday) <b>77</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>VA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Garrison</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Foxleigh</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>			13c. CITY OR TOWN <b>BALTO</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>1214 3rd Street</b>			14. FATHER'S NAME First Middle Last <b>DANIEL LITAKER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MOLLIE MCGIBBONS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>242-22-3836</b>			17. INFORMANT Address <b>Mrs Nell Hudson</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL infarction.</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201 Fracture Rt hip.</b>											
19a. DATE OF OPERATION <b>8-3-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture Rt hip</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-10</b> , 19 <b>68</b> , to <b>8-15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-14</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Vicente M. Ruocco MD</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>8-15-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>VICENTE M RUOCO MD</b>						22e. ADDRESS <b>Spring Grove St. Hosp. to Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>8/16/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>CAROLINA MEM. PARK</b>			23d. LOCATION (City or Town) (County) (State) <b>KANNAPOLIS N.C.</b>		
24. FUNERAL DIRECTOR <b>J.G. CONNELLY 5045</b>						ADDRESS <b>300 MA CE</b>			25a. RECD BY REGISTRAR <b>AUG 19 1968</b>		
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First ELsie		Middle J.		Last BARLOW		2a. DATE OF DEATH Month Day Year Aug. 9 1968		2b. HOUR 5:35 PM		
3. SEX Female		4. RACE White			5. DATE OF BIRTH 12-15-1902			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Louisiana		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Balto. 21212			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armacost N. H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleslady			12b. KIND OF BUSINESS OR INDUSTRY Dress Shop				
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto. 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9207 Satyr Hill Rd.				
14. FATHER'S NAME First Middle Last Herbert L. Janin			15. MOTHER'S MAIDEN NAME First Middle Last Julia L. Fassmann										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 434-12-1959A			17. INFORMANT Address Miss Althea Barlow 9207 Satyr Hill							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PANCREAS 157.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Metastases DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from July 31, 1968, to Aug 9, 1968, that (I) (we) lost saw the deceased alive on August 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Larry G. Tilley MD					DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-10-68				
22d. PHYSICIAN'S NAME (Type) Dr. Larry G. Tilley					22e. ADDRESS 1713 Taylor Ave., Balto. Md. 21234								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Removal-Burial 8-13-68				Lafayette No. 1			New Orleans La.						
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.						25a. RECEIVED BY REGISTRAR DATE AUG 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

(15)

TO : SAC, NEW YORK (100-100000)  
FROM : SAC, BALTIMORE (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

100-100000

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11023												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												11031			
Cassandra Fedalis												CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print) <b>BARRETT, Infant Female</b>						2a. DATE OF DEATH <b>8 24 68</b>						2b. HOUR <b>12:15</b>															
3. SEX <b>Female</b>				4. RACE <b>Cauc</b>				5. DATE OF BIRTH <b>8-23-68 2:53p.m.</b>				6. AGE (In years last birthday) <b>— YRS.</b>				IF UNDER 1 YEAR MONTHS <b>1</b>		IF UNDER 24 HRS. HOURS <b>1</b> MIN.									
7a. BIRTHPLACE (State or foreign country) <b>Baltimore Co.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Baltimore County</b> Md.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC 6701 N. Charles St.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Infant</b>				12b. KIND OF BUSINESS OR INDUSTRY															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>				13b. COUNTY <b>Balto</b>				13c. CITY OR TOWN <b>Catonsville</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>21207 1330 Lafayette Ave. RD.</b>													
14. FATHER'S NAME First <b>Charles</b> Middle <b>Francis</b> Last <b>Barrett</b>						15. MOTHER'S MAIDEN NAME First <b>Davidson</b> Middle <b>Judith</b> Last <b>Curine Barrett</b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Chs.F. Barrett, 1330 Lafayette Ave. RD. 21207</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyalin<sup>e</sup> Membrane Disease</b> <b>7761</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7735 Prematurity</b>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <b>Joseph Kaplan M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>8/24/68</b>																			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Kaplan M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>8-26-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto, Md.</b>															
24. FUNERAL DIRECTOR <b>Johnson Funeral Home</b>				ADDRESS <b>8521 Loch Raven Blvd.</b>				25a. REC'D BY REGISTRAR <b>AUG 27 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)  
304M Rev. 1/68

11024		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11032	
1. DECEASED-NAME (Type or print) <b>Joseph W. Barton</b>			2a. DATE OF DEATH <b>August 31- Day 1968</b>			2b. HOUR <b>7:15 pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 9- 1890</b>		6. AGE (In years last birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>400 Westfield Road</b>		12a. USUAL OCCUPATION (Kind of work done during last of working life) <b>Ret. Otis Elevator Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Bowley's Quarter's</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>Barton</b> Last <b>Barton</b>		15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Wells</b> Last <b>Section Rd.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes- Army WW I</b>		16b. SOCIAL SECURITY NO. <b>214-03-0414A</b>		17. INFORMANT Address <b>Daughter, Mrs. Catherine B. Gladden #13, e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of PROSTATE C</b> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos =</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>177X Rheumatoid ARTHRITIS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Law</b> , 19 <b>68</b> to <b>Aug 25, 1968</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Aug 25, 1968</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death.							
22b. SIGNATURE <b>M B Davis</b>		22c. DATE SIGNED <b>September 1- '68</b>		22d. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis, M.D.</b>			
22e. ADDRESS <b>6800 Mornington Rd. Dundalk, Md. 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 3-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, Dundalk, Md. 21222</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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RECORD OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
LOUISE			BARVIR			Aug. 25, 1968			1:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		June 14, 1892		76 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Czechoslovakia		Czech.				Czechoslovakia Balto. Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville		Ridgeway Manor Nursing Home		Supervisor		Guilford Box Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Baltimore		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		608 N. Curley St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last			First Middle Last		
Anton			Franc			Kathryn Stuchlika					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
			217-20-8960			Edward J. Barvir, son, 409 N. Linwood Av.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										1 day	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
331X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>68</u> , to <u>29 Aug</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>24 Aug</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>William Goodman, MD.</u>						<input checked="" type="checkbox"/>				27 Aug 68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
Dr. William Goodman				1334 Sulphur Spring Road							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		8/28/68		Bohemian National Cem.		Baltimore, Md.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.				2601 E. Madison St.		DATE AUG 30 1968		<u>Charles Judge</u>			

11003

11003

RECORDS OF DEATH

NAME: [illegible] DATE OF BIRTH: [illegible] DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF NEXT OF KIN: [illegible]

NAME OF WITNESS: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF GRAVE: [illegible]

NAME OF MONUMENT: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF NEXT OF KIN: [illegible]

NAME OF WITNESS: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF GRAVE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11026										
11034										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last					Month Day Year					
ELIZABETH BENSER					8-6-68					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		2b. HOUR		
F		W		6-22-1884		84 YRS.		6:40 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Md.			U.S.A.			BALTIMORE			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson			STELLA MARS Hospice			HOUSE WIFE				
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			BALTIMORE			BALTIMORE			3111 E Monument St.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
CHRISTIAN BLAZER					THERESA GRADEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
					218-01-82290					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>ASCVD-</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> , 19 <u>61</u> , to <u>8/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E. Lee Robbins, M.D.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8/6/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>E. Lee Robbins, M.D.</u>					22e. ADDRESS <u>812 Mockingbird Lane. Balto. Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		8/9/68		Holy Redeemer Cemetery			Belair Road, Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Frederick D. Miller, Inc 3019 Monument St.					DATE <u>AUG 12 1968</u>		<u>Charles Judge</u>			

11034

OFFICE OF THE DIRECTOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11027 Item 8 Film G403 8/26/68 11035 <b>CERTIFICATE OF DEATH</b>											
1. DECEASED-NAME (Type or print) First Middle Last <b>Margaret Bernhardt</b>						2a. DATE OF DEATH Month Day Year <b>8 17 1968</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH <b>2-15-1897</b>			6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Carney</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2900 Cub Hill Rd</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Carney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2900 Cub Hill Road 34</b>		
14. FATHER'S NAME First Middle Last <b>John Michel</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Eurich</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-12-96325</b>		17. INFORMANT Address <b>Mr Henry Bernhardt 2900 Cub Hill Road 21234</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1830</b> IMMEDIATE CAUSE (a) <b>Carcinomatous ascites</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1750</b> (b) <b>Ovarian Ca.</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Congestive heart failure Compensated; Diabetes Mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 12 1968</b> , to <b>Aug. 18 1968</b> , that (I) (we) last saw the deceased alive on <b>July 12 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>F. T. KASIK JR.</b>						22c. DATE SIGNED <b>8/18/68</b>		22d. PHYSICIAN'S NAME (Type) <b>F. T. KASIK JR.</b>			
22e. ADDRESS <b>9005 Harford Rd Balto Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-20-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery Baltimore Co. Md</b>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road 21236</b>						25a. REC'D BY REGISTRAR <b>AUG 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

11008

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Chronic congestive heart failure, Diabetes Mellitus  
Chronic

P. O. Box 1234  
F. T. K. A. S. K. V. R.  
X  
2/18/68  
2002 Hartford R. & B. Co. Inc.

AUG 21 1980

CERTIFICATE OF DEATH

11028

11036

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1510 Francke Ave.</u>				d. STREET ADDRESS <u>1510 Francke Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>George M. Barry</u>				4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1968</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1907</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge-Circuit Court</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired - Law</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lutherville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jasper Mauduit</u>				14. MOTHER'S MAIDEN NAME <u>Helen Leisenring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-38-2738</u>		17. INFORMANT <u>George Barry, Jr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>185X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <u>Broncho pneumonia</u> <u>Hepatic metastatic carcinoma</u> <u>Carcinoma of the Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>177X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>8-21-1968</u> , to <u>8-22-1968</u> , that (1) (we) last saw the deceased alive on <u>8-21-1968</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>K. A. Manley</u>				22b. DATE <u>8-22-68</u>		22c. PHYSICIAN'S NAME (Type) <u>K. A. MANLEY, M.D.</u>	
22d. ADDRESS <u>2045 York Road, Timonium, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>8/22/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>AUG 22 1968</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11935

CERTIFICATE OF DEATH

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11029		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11037		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First Mary	Middle Elizabeth	Last BEUKEMA	2a. DATE OF DEATH Month 8 Day 14 Year 68		2b. HOUR 3:20 <sup>am</sup>
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/5/48		6. AGE (In years last birthday) 20 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent		12b. KIND OF BUSINESS OR INDUSTRY none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Westmoreland Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5409 Duvall Drive
14. FATHER'S NAME First Middle Last Henry Shaw Beukema			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Connell Bradley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>476X</u> (b) <u>Bilateral pneumonia and lung abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>490X</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Spastic quadriplegia and mental retardation</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (this hospital) attended the deceased from <u>7/5</u> , 19 <u>56</u> , to <u>8/14</u> , 19 <u>68</u> , that (we) lost saw the deceased alive on <u>8/14</u> , 19 <u>68</u> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Alan S. Greenberg, M.D.</u> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/15/68</u>		
22d. PHYSICIAN'S NAME (Type) Alan S. Greenberg, M.D.				22e. ADDRESS Rosewood State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 17, 68		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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1. *Staphylococcus aureus*

THE JOURNAL OF THE

1975-1976

1. *Phragmites australis* (Cav.) Trin. ex Steud.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11038

1. DECEASED-NAME (Type or print) <b>JOHN</b>			First <b>JOHN</b>	Middle <b>L.</b>	Last <b>BLAIR</b>	2a. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>6:45 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 6, 1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b>74</b>	OAYS <b>74</b>	IF UNDER 24 HRS HOURS <b>74</b>	MIN. <b>74</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					Md.
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>House-in-the-Pines Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem St.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3520 Greenmount Ave.</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>P.</b> Last <b>Blair</b>			15. MOTHER'S MAIDEN NAME First <b>Adelaide</b> Middle <b>E.</b> Last <b>Hucht</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>323-01-8297</b>		17. INFORMANT Address <b>Theodore Blair - 5708 Pope St., Baltimore</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the Breast</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>6 mos</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-11-1968</b> to <b>8-8-1968</b> , that (I) (we) last saw the deceased alive on <b>8-6-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wilmer K. Gallagher M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>Aug. 8, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, M.D.</b>						22e. ADDRESS <b>6209 Frederick Rd., Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-10-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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Stressful Life

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |                          |   |  |  |  |  |          |
|---|---------|--|--------------------------|---|--|--|--|--|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |                          |   |  |  |  |  |          |
| CERTIFICATE OF DEATH  |         |  |                          |   |  |  |  |  |          |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First Middle Last        |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR |
| Albert Joseph Jude BLATTERMAN   |         |  |                          |   |  | Month 8 Day 11 Year 68   |  |  | 8:50 PM  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH         |   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |          |
| Male  | White   |  | 2/14/65                  |   |  | 3 YRS.   |  |  |          |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |          |
| Maryland  |         | U.S.A.   |                          |   |  | Baltimore Md.  |  |  |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY        |          |
| Owings Mills  |         | Rosewood State Hospital  |                          |   | Dependent  |  |  | none                                     |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                   |          |
| Maryland  |         |  |                          | Baltimore   |  |  |  | 227 South High Street                    |          |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME |   |  |  |  |  |          |
| First Middle Last   |         |  | First Middle Last        |   |  |  |  |  |          |
| Albert Joseph Blatterman  |         |  | Giovanna Marie Aquia     |   |  |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |         |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address  |  |  |  |          |
| no  |         |  | none                     |   | Rosewood Records, Owings Mills, Maryland   |  |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |                          |   |  |  |  |  |          |
| PART I. DEATH WAS CAUSED BY:  |         |  |                          |   |  |  |  |  |          |
| IMMEDIATE CAUSE (a) <u>Anterior lateral</u>   |         |  |                          |   |  |  |  |  |          |
| 742X DUE TO, OR AS A CONSEQUENCE OF   |         |  |                          |   |  |  |  |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |  |                          |   |  |  |  |  |          |
| (b) <u>Hydrocephalus</u>  |         |  |                          |   |  |  |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                          |   |  |  |  |  |          |
| (c)   |         |  |                          |   |  |  |  |  |          |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |         |  |                          |   |  |  |  |  |          |
| Terminal 3 yrs.   |         |  |                          |   |  |  |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |                          |   |  |  |  |  |          |
| 752X  |         |  |                          |   |  |  |  |  |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |          |
|   |         |  |                          |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | yes  |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |          |
|   |         | HOUR A.M. Month Day Year P.M. 19   |                          |   |  |  |  |  |          |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |          |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |         |  |                          |   |  |  |  |  |          |
| 22a. I certify that (this hospital) attended the deceased from 10/21, 1965, to 8/11, 1968, that (we) (I) saw the deceased alive on 8/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) (did) (did not) view the body after death. |         |  |                          |   |  |  |  |  |          |
| 22b. SIGNATURE  |         |  |                          |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |          |
| Richard A. Jones, M.D.  |         |  |                          |   |  |  | 8/12/68  |  |          |
| 22d. PHYSICIAN'S NAME (Type)  |         |  |                          |   | 22e. ADDRESS   |  |  |  |          |
| Richard A. Jones, M.D.  |         |  |                          |   | Rosewood St. Hosp., Owings Mills, Md.  |  |  |  |          |
| 23a. BURIAL, CREMATION, or other disposition  |         | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |          |
| Burial  |         | Aug. 14, 68  |                          | Rosewood Cemetery   |  | Owings Mills, Md.  |  |  |          |
| 24. FUNERAL DIRECTOR ADDRESS  |         |  |                          |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |          |
| J. F. Eline & Sons Reisterstown, Md.  |         |  |                          |   | DATE AUG 16 1968   |  | Charles Judge  |  |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>JOHN</b>  |  |  |  |  |  | First  |  | Middle  |  | Last   |  |
| 2. DATE OF DEATH   |  |  |  |  |  | Month <b>12</b>  |  | Day <b>68</b>   |  | Year   |  |
| 3. SEX<br><b>Male</b>  |  |  |  |  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>December 21, 1905</b>  |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, Md.</b>   |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Baltimore Med. Cen.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Steamfitter</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  |  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>John Bleach</b>  |  |  |  |  |  | First  |  | Middle  |  | Last   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Cora Barber</b>   |  |  |  |  |  | First  |  | Middle  |  | Last   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-8140</b>   |  | 17. INFORMANT<br><b>Alma A. Bleach -2841 Roborn Ave. -21234</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>Extensive myocardial infarct</b>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>4109</b>   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Bronchopneumonia; metastatic synovial sarcoma to bones and liver</b>   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> , 19 <b>68</b> , to <b>8/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Rudiger Breiteneker</b>   |  |  |  |  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>8/12/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rudiger Breiteneker, M.D.</b>   |  |  |  |  |  |  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>8-15-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>John C. Miller Inc. - 6415 Belair Rd.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Young</b>   |  |  |  |

MEDICAL CERTIFICATION

03012

*Robertson*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|
| 11033   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 11041  |  |  |  |  |                                |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Jack nmi. Bloom   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH<br>08 Month 27 Day 68 Year  |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>5:43 P.M.                                |  |  |  |  |                                |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>8/12/10   |  |  |  |  | 6. AGE (In years last birthday)<br>58 YRS.                           |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                       |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>POLAND   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Balto. Co. Gen. Hosp. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>SALESMAN  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>REAL ESTATE                     |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  |  |  | 13b. COUNTY<br>Balto.   |  |  |  |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 13e. STREET AND NUMBER<br>7419 Shirley Rd. #7                        |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>GOEL   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>JENNIE Silverman  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown<br>NO   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                     |  |  |  |  | 17. INFORMANT Address<br>MRS. ROSE BLOOM, 7419 SHIRLEY ROAD #21207  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>7 weeks</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 68   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 6, 1968</u> , to <u>AUG 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>AUG 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE<br>Fausto Q. Aquino, Jr.   |  |  |  |  |   |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED<br>8/27/68  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>FAUSTO Q. AQUINO, JR.   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN. HOSP.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  |  | 23b. DATE<br>8-28-68  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ANSHE EMUNAH (AITZ CHAIM)   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |  |  |   |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 29 1968                          |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. [Signature] |  |  |  |  |                                |  |  |  |  |

11001

CERTIFICATE OF DEATH

11001

DATE OF DEATH: 11-11-1918

PLACE OF DEATH: 11001

CAUSE OF DEATH: 11001

AGE: 11001

SEX: 11001

EDUCATION: 11001

OCCUPATION: 11001

RELIGION: 11001

ETHNICITY: 11001

DATE OF BIRTH: 11001

PLACE OF BIRTH: 11001

DATE OF MARRIAGE: 11001

PLACE OF MARRIAGE: 11001

DATE OF DEATH: 11001

PLACE OF DEATH: 11001

CAUSE OF DEATH: 11001

AGE: 11001

SEX: 11001

EDUCATION: 11001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | CERTIFICATE OF DEATH   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print)   |  | First Middle Last  |  | 20. DATE OF DEATH  |  | 2b. HOUR  |  |
| EDGAR  |  | PAUL BODE  |  | Month 8 Day 8 Year 68  |  | 12:35 PM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  |
| Male   |  | Cau.   |  | June 14, 1968  |  | 67 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |
| Maryland   |  | U. S. A.   |  |  |  | BALTIMORE Md.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| TOWSON   |  | Greater Balto. Med. Center   |  | Mechanic   |  | Cement  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland   |  | Baltimore  |  | Cockeysville   |  | 147 Church Lane   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |
| First Middle Last  |  | First Middle Last  |  |  |  |   |  |
| Paul peter   |  | Bode Annie   |  |  |  | Miller  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address#  |  |
| No (or unknown)  |  | 217-05-5081  |  | Mrs. Gladys M. Bode, Same as 13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE  |  |  |  |  |  |   |  |
| 1621 DUE TO, OR AS A CONSEQUENCE OF R.L.L. ATELECTASIS & R HEMIDIAPHRAGM PARALYSIS   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LUNG & PULMONARY EMPHYSEMA   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)  |  |  |  |  |  |   |  |
| 163x   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |
|  |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
|  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
|  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/25/68, 1968, to 8/8/68, 1968, that (I) (we) last saw the deceased alive on 8/8/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS  |  |
| George I. Miller M.D.  |  | 8/8/68   |  | GEORGE PIKLER M.D.   |  | G.B.M.C.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |
| BURIAL   |  | Aug. 12, 1968  |  | Poplar Grove Cemetery  |  | Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Wm. Cook-Brooks Towson, 1050 York Road   |  | DATE AUG 12 1968   |  | Charles Judge  |  |   |  |
| Towson, Maryland 21204   |  |  |  |  |  |   |  |

11048

11048

*John Miller*

11048

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
|--|--|---|--------------|---|--|---|---|--|--------------------------------|--|--------------------------------|-----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
| CERTIFICATE OF DEATH   |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br>Mae |   |  | Middle<br>Geist   |   | Last<br>Bonner   |                                | 2a. DATE OF DEATH<br>Month Day Year<br>August 20, 1968 |                                | 2b. HOUR<br>9:40 a.m. |  |
| 3. SEX<br>female   |  | 4. RACE<br>white  |              | 5. DATE OF BIRTH<br>May 1, 1882   |  |   | 6. AGE (In years<br>last birthday)<br>86 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |                       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |                                |  |                                |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |              |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>housewife |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Ret. Own Home                |                                |  |                                |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>if institution: Residence before<br>admission) STATE<br>Md.   |  | 13b. COUNTY<br>Cecil  |              | 13c. CITY OR TOWN<br>Colora   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>R.F.D.                                     |                                |  |                                |                       |  |
| 14. FATHER'S NAME<br>First Middle Last<br>George Geist   |  |   |              | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Nancy Bolger  |  |   |   |  |                                |  |                                |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No  |  | 16b. SOCIAL SECURITY NO.<br>201-18-9729A  |              | 17. INFORMANT<br>Address<br>Records: SPRING GROVE STATE HOSPITAL  |  |   |   |  |                                |  |                                |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death, 10 Min.<br>4109 DUE TO, OR AS A CONSEQUENCE OF with PVB, Cardiomegaly, Con. Ht. Failure<br>(b) Arteriosclerotic, Cardiovascular Ht. Dis. 3 years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerosis, Generalized, Senile. 20 years |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (do not senility)<br>Malnutrition and dehydration secondary to feeding problem secondary   |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |                                |                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |                                |  |                                |                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |                                |  |                                |                       |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Oct. 16, 1965, to Aug. 20, 1968, that (I) (we) lost<br>saw the deceased alive on Aug. 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |              |   |  |   |   |  |                                |  |                                |                       |  |
| 22b. SIGNATURE<br><i>Anthony J. Yeung</i>  |  |   |              | 22c. DATE SIGNED<br>8-20-68   |  |   |   | 22d. PHYSICIAN'S<br>NAME (Type)<br>Anthony J. Yeung, M.D.            |                                |  |                                |                       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>8-22-68  |              | 23c. NAME OF CEMETERY OR CREMATORY<br>West Nottingham Colora  |  | 23d. LOCATION (City or Town) (County) (State)<br>Cecil Md.                                      |   | 25a. REGISTRAR<br>AUG 22 1968  |                                |  |                                |                       |  |
| 24. FUNERAL DIRECTOR<br><i>Donald E. Staller</i>   |  | ADDRESS<br>Dising Summit  |              | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  | DATE  |   |  |                                |  |                                |                       |  |

MEDICAL CERTIFICATION

11023

U. S. DEPT. OF JUSTICE

11023

RECEIVED  
FEB 10 1964  
U. S. DEPT. OF JUSTICE

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11036

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11044

|  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  | First<br><b>EDGAR</b>  |  | Middle<br><b>MELVIN</b>  |  | Last<br><b>BOSLEY Sr.</b>   |  | 2a. DATE KNOWN OF DEATH<br>Month <input checked="" type="checkbox"/> Day Year       |  | 2b. HOUR<br>M                                    |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>1/22/03</b>   |  | 6. AGE (In years last birthday)<br><b>65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>August</b> Day <b>24</b> , Year <b>19 68</b>   |  | 2d. HOUR<br><b>2:30 P.M.</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Phila. Rd Philadelphia Road</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Building Contractor</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Perry Hall</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>137 Pepper Hill Road</b>                               |  |  |  |
| 14. FATHER'S NAME<br>First <b>James</b> Middle <b>Emory</b> Last <b>Bosley</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Delia</b> Middle <b>Brown</b> Last <b>Brown</b>                               |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-12-2150</b>   |  | 17. INFORMANT<br><b>Edna C Bosley</b>  |  | ADDRESS<br><b>Same</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shotgun wound of mouth</b><br><b>955X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>976X</b>  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH <b>between 1:30 P.M. 8-24 1968</b>  |  | 21b. TIME OF INJURY Month, Day, Year<br><b>1:00 P.M. 8-24 1968</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot self</b>  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Quarry</b>                      |  | 21f. LOCATION Street or R.F.D. No.<br><b>Campbell's Quarry Philadelphia Road</b>   |  | City or Town<br><b>Essex</b>  |  | County<br><b>Baltimore</b>  |  | State<br><b>Md.</b>                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>  |  | EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |  | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                      |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |
| ADDRESS (Street, city, town, or county)  |  | 22b. DATE SIGNED<br><b>August 25, 1968</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/27/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc</b>  |  | ADDRESS<br><b>Baltimore, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 26 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |  |

11311

UNITED STATES DEPARTMENT OF THE INTERIOR

1900



RECEIVED

DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 157-4  
30M REV. 1-68

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 11037  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  |   |  | 11045   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Bridget Mary Gertrude BOWENS  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>August 31 1968   |  | 2b. HOUR<br>11:20 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>October 20, 1887  |  | 6. AGE (In years<br>last birthday)<br>80 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Ireland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>1001 West Joppa Road |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>NON   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Teacher   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>1001 West Joppa Road   |  | 14. FATHER'S NAME<br>First Middle Last<br>John BOWENS   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Anne FEELEY  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>- - - -   |  | 17. INFORMANT<br>1001 West Joppa Road<br>Mission Helpers of the Sacred Heart  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4107 Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 hour                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201 none   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>none   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 30, 1968, to June 19, 1968, that (I) (we) last<br>saw the deceased alive on June 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Patrick C. Phelan Jr. MD   |  |   |  | 22c. DATE SIGNED<br>Sept 1, 1968  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Patrick C. Phelan Jr.  |  |
| 22e. ADDRESS<br>2 Burnbrae Road, Towson, Md.   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br>Sep 3, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Convent Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>1001 W. Joppa Rd. Towson, Md.                  |  |
| 24. FUNERAL DIRECTOR<br>J. E. Lowell Lemmon 4611 Park Heights Ave.   |  |   |  | 25a. REC'D BY REGISTRAR<br>SEP 4 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |



1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 11038  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 11046   |   |
| Item#5,6, Film#405 10/2/68 km  |  | CERTIFICATE OF DEATH   |   |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | 2a. DATE OF DEATH   |   | 2b. HOUR  |
| First Middle Last<br>Joseph Maynard Bowman   |  |  | Month Day Year<br>August 14, 1968   |   | 3:25 p.m.   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| male   | white  | Nov. 3, 1907/1906  |   | 60 yrs.   |   |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH  |   |   |
| Md.  | U. S.  |  | Baltimore Md.   |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                       |
| Catonsville  | SPRING GROVE STATE HOSP.   |  | newspman  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET AND NUMBER  |   |
| Md.  | Montgomery   | Burtonsvle.  |   | Mackey Road   |   |
| 14. FATHER'S NAME First Middle Last  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |   |   |
| James Bowman   |  | Mary Peters  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |
|  |  |  |   | Records: SPRING GROVE STATE HOSPITAL  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, massive,  |  |  |   |   | 1 hr.   |
| 454.9 DUE TO, OR AS A CONSEQUENCE OF (b) Pelvic Vein thrombosis, deep, presumed.   |  |  |   |   | unk.  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 460.8 (c) Varicose Veins and peripheral vascular Dis. 10 yrs  |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |   |   |   |
| Arteriosclerosis, Generalized with ASCVD and peripheral vascular D.  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1958, to Aug. 14, 1968, that (I) (we) lost saw the deceased alive on Aug. 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |
| 22b. SIGNATURE   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED  |   |
| Anthony J. Young, M.D.   |  |  |   | 8-14-68   |   |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |   |   |   |
|  |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)                                   |   |
| Burial   | 8-21-68  | Union Cemetery   |   | Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                              |   |
| De Witt Donaldson  |  | Lurep, mcf   |   | AUG 26 1968 Charles Judge   |   |

11026

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11033   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11047                       |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH<br>Month Day Year  |  |  |  |  | 2b. HOUR   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Rev. John   |  |  |  |  | Howard   |  |  |  |  | Braunlein  |  |  |  |  | August 29 68   |  |  |  |  | 5.40 P.M.                   |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years lost birthday)  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  | White  |  |  |  |  | 8-13-1890  |  |  |  |  | 78 YRS.  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Towson  |  |  |  |  | St. Joseph Hospital  |  |  |  |  | Minister   |  |  |  |  | Religion   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  | Baltimore  |  |  |  |  | Baltimore  |  |  |  |  | YES  |  |  |  |  | 1558 Waverly Way 21212      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| John G. Braunlein   |  |  |  |  | K. Lober   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  | 219-32-0292-A  |  |  |  |  | Mrs. Bessye P. Braunlein   |  |  |  |  | (Same)   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| (b) <u>Congestive heart failure</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| (c) <u>Arteriosclerotic cardio vascular disease</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4221  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION  |  |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/26/</u> , 19 <u>68</u> , to <u>8/29/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/29/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED            |  |  |  |  |  |  |  |  |  |
| Luis E. Renjel  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8-29-68                     |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Luis Renjel M.D.  |  |  |  |  |  |  |  |  |  | 7620 York Rd., Towson, Md. 21204   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  | 9/2/1968   |  |  |  |  | Loudon Park  |  |  |  |  | Baltimore Md.  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |
| H.W. Jenkins & Sons Co.   |  |  |  |  |  |  |  |  |  | 4905 York Rd. Balto. 12, Md.   |  |  |  |  | AUG 30 1968  |  |  |  |  | Charles Judge               |  |  |  |  |  |  |  |  |  |

5252



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>John   |  |  | Middle<br>C.  |  |  | Last<br>Braunschweiger  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>August 19 1968                    |  |  | 2b. HOUR<br>7.45 PM             |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>10-17-1897  |  |  | 6. AGE (In years last birthday)<br>70 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |  | IF UNDER 24 HOURS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CHAFFEUR   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BREWERY  |  |  |  |  |  |                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>BALTO  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>1623 DARTFORD RD.<br>3130 Elliott Street 21224 |  |  |                                 |  |  |
| 14. FATHER'S NAME First Middle Last<br>HENRY - BRAUNSCHWEIGER   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ROSE SCHUAFLIN  |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (or or unknown) YES  |  |  | (If yes give war or dates of service)<br>ARMY-WWI   |  |  | 16b. SOCIAL SECURITY NO.<br>217 05 0101   |  |  | 17. INFORMANT<br>Mrs. Ellen N. Braunschweiger   |  |  | Address<br>1623 Dartford Rd  |  |  |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute hemorrhagic pyelonephritis</b><br>188X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Obstructive uropathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma urinary bladder</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |  |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>1810   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                                 |  |  |
| 22a. I certify that (this hospital) attended the deceased from 8/19/ 1968, to 8/19/ 1968, that (I) (we) last saw the deceased alive on 8/19/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| 22b. SIGNATURE<br>Cillian   |  |  | DEGREE  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br>8/20/68   |  |  |  |  |  |                                 |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Ines Cillian, M.D.  |  |  | 22e. ADDRESS<br>7620 York Road, Towson, Md. 21204   |  |  |   |  |  |   |  |  |  |  |  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>8-23-68  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. NATIONAL Cem.  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO. MD                                      |  |  |  |  |  |                                 |  |  |
| 24. FUNERAL DIRECTOR<br>Hartley - 2334 Jefferson St.  |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 22 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge   |  |  |  |  |  |                                 |  |  |

11018

RECEIVED

Acute haemorrhagic pyelonephritis

Chronic pyelonephritis

Chronic pyelonephritis

2

John William, M.D.

AUG 10 1958

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form "PMS-3". Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11049

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11049

|   |         |  |        |   |                         |   |                  |   |                          |  |          |                                   |
|---|---------|--|--------|---|-------------------------|---|------------------|---|--------------------------|--|----------|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Lost  | 2a. DATE KNOWN OF DEATH |   |                  | <input checked="" type="checkbox"/> Month   | Day                      | Year   | 2b. HOUR |                                   |
| CLARA   |         | V  |        | BRENNER   | Aug 2                   |   |                  | 1968  | 12                       | PM   | 5:5      |                                   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years lost birthday)   | IF UNDER 1 YEAR         |   | IF UNDER 24 HRS. |   | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |                                   |
| F   | W       | 9-28-94  |        | 73 YRS.   | MONTHS                  |   | DAYS             |   | Month Day Year           |  | 12 PM    |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED  |                         | <input checked="" type="checkbox"/> NEVER MARRIED |                  | 9. COUNTY OF DEATH  |                          | Md   |          |                                   |
| Ind.  |         | W. S. A.   |        | WIDOWED   |                         | DIVORCED  |                  | BALTO.  |                          |  |          |                                   |
| 10. CITY OR TOWN OF DEATH   |         |  |        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |                         |   |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                          |  |          | 12b. KIND OF BUSINESS OR INDUSTRY |
| MT. WILSON  |         |  |        | MT. WILSON STATE HOSP.  |                         |   |                  | Housewife.  |                          |  |          | None.                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  |        | 13b. COUNTY   |                         | 13c. CITY OR TOWN                                 |                  | 13d. INSIDE CITY LIMITS?  |                          | 13e. STREET AND NUMBER                       |          |                                   |
| MD.   |         |  |        | BALTO.  |                         | ESSEX   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                          | 306 Woodward Dr.                             |          |                                   |
| 14. FATHER'S NAME   |         |  |        | 15. MOTHER'S MAIDEN NAME  |                         |   |                  |   |                          |  |          |                                   |
| JOHN  |         |  |        | KANE  |                         | Unknown   |                  |   |                          |  |          |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  |        | 16b. SOCIAL SECURITY NO.  |                         | 17. INFORMANT ADDRESS                             |                  |   |                          |  |          |                                   |
| No  |         |  |        | 217-01-72978  |                         | Int. Wilson Hosp. Records                         |                  |   |                          |  |          |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |   |                         |   |                  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                                   |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>  |         |  |        |   |                         |   |                  |   |                          | 3 da   |          |                                   |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Decompensated arterio Sclerotic</u>  |         |  |        |   |                         |   |                  |   |                          | 3 mo.  |          |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>C-V. Disease</u>  |         |  |        |   |                         |   |                  |   |                          |  |          |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |        |   |                         |   |                  |   |                          |  |          |                                   |
| 4221  |         |  |        |   |                         |   |                  |   |                          |  |          |                                   |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |                         |   |                  | 20. AUTOPSY?  |                          |  |          |                                   |
|   |         |  |        |   |                         |   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                          |  |          |                                   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                         |   |                  |   |                          |  |          |                                   |
| None  |         | 19   |        |   |                         |   |                  |   |                          |  |          |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.  |                         | City or Town                                      |                  | County  |                          | State  |          |                                   |
| None  |         | None   |        |   |                         |   |                  |   |                          |  |          |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |   |                         |   |                  |   |                          |  |          |                                   |
| ACTUAL SIGNATURE <u>D.D. Caples</u>   |         |  |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |                         |   |                  | 22b. DATE SIGNED  |                          |  |          |                                   |
| EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>   |         |  |        | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                             |                         |   |                  | Aug 2 '68   |                          |  |          |                                   |
|   |         |  |        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                     |                         |   |                  |   |                          |  |          |                                   |
|   |         |  |        | ADDRESS (Street, city, town, or county)   |                         |   |                  |   |                          |  |          |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                         | 23d. LOCATION (City or Town)                      |                  | (County)  |                          | (State)                                      |          |                                   |
| BURIAL  |         | 8/6/68   |        | OAK LAWN  |                         | BALTO.  |                  | MD  |                          |  |          |                                   |
| 24. FUNERAL DIRECTOR  |         |  |        | ADDRESS   |                         |   |                  | 25a. REC'D BY REGISTRAR   |                          | 25b. REGISTRAR'S SIGNATURE                   |          |                                   |
| J.G. CONNELLY SONS  |         |  |        | 300 MACE  |                         |   |                  | AUG 6 1968  |                          | Charles Judge                                |          |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It must be removed from the certificate, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 1. DECEASED-NAME :<br>(Type or print)  |  |  | First<br><i>Emma</i>   |  |  | Middle<br><i>J.</i>   |  |  | Last<br><i>Broemer</i>  |  |  | 2a. DATE OF DEATH<br>Month<br><i>Aug.</i> Day<br><i>3,</i> Year<br><i>1968</i> |  |  | 2b. HOUR<br><i>9:45</i> M         |  |  |
| 3. SEX<br><i>female</i>  |  |  | 4. RACE<br><i>white</i>  |  |  | 5. DATE OF BIRTH<br><i>April 6, 1891</i>  |  |  | 6. AGE (In years last birthday)<br><i>77</i> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |  |  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Chesapeake Manor NH</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Sec. Treas.</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>clothing Co</i>   |  |  |  |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Mich.</i>  |  |  | 13b. COUNTY<br><i>13</i>   |  |  | 13c. CITY OR TOWN<br><i>Detroit</i>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER   |  |  |                                   |  |  |
| 14. FATHER'S NAME<br>First<br><i>August</i>  |  |  | Middle<br><i>Broemer</i>   |  |  | Last<br><i>Broemer</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><i>Hermine</i>   |  |  | Middle<br><i>Boring</i>  |  |  | Last<br><i>Boring</i>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><i>no</i>   |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><i>372-05-9355</i>  |  |  | 17. INFORMANT<br>Address<br><i>Baltimore</i><br><i>Paul A. Broemer-2208 Gibbons Ave.</i>        |  |  |  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i><br><i>1830</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Carcinoma of Ovary</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 yrs</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 months</i>                |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>1750</i>  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/4, 1968</i> to <i>8/3, 1968</i> , that (I) <del>(we)</del> lost saw the deceased alive on <i>2/3, 1968</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <i>(did)</i> (did not) view the body after death.                             |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE<br><i>Charles O'Donnell</i>   |  |  | DEGREE<br><i>M.D.</i>  |  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  | 22c. DATE SIGNED<br><i>8/5/68</i>   |  |  |  |  |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Charles O'Donnell</i>   |  |  | 22e. ADDRESS<br><i>7502 York Road</i>  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>   |  |  | 23b. DATE<br><i>8/6/68</i>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore, Md. Cem.</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>                          |  |  |  |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br><i>Leonard J. Ruck, Inc Baltimore, Md.</i>   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br><i>AUG 5 1968</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. George</i>  |  |  |  |  |  |                                   |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
|---|--|----------------------|--|--|--|---|--------------------------|---------------------------------|--|------------------|-----------------|----------|------------------|--|
| 11043   |  | CERTIFICATE OF DEATH |  |  |  |   |                          |                                 |  | 11051            |                 |          |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                      | First  |  | Middle   |   | Last                     |                                 | 2a. DATE OF DEATH  |                  |                 | 2b. HOUR |                  |  |
| Carrie  |  |                      | B.   |  | Brown  |   | 8                        |                                 |  | 8                |                 | 68       |                  |  |
| 3. SEX  |  |                      | 4. RACE  |  | 5. DATE OF BIRTH   |   |                          | 6. AGE (In years last birthday) |  |                  | IF UNDER 1 YEAR |          | IF UNDER 24 HRS. |  |
| Female  |  |                      | W  |  | 9/20/88  |   |                          | 79                              |  |                  | MONTHS          |          | OAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |                      | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |                          | 9. COUNTY OF DEATH              |  |                  |                 |          |                  |  |
| Balto. Md.  |  |                      | U.S.A.   |  |  |   |                          | Baltimore Md.                   |  |                  |                 |          |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                          |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                  |                 |          |                  |  |
| Baltimore 21204   |  |                      | Greater Balto. Med. Center   |  |  | Homemaker   |                          |                                 | Own Home   |                  |                 |          |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                      | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? |                                 | 13e. STREET AND NUMBER   |                  |                 |          |                  |  |
| Md.   |  |                      | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 21218                    |                                 |  |                  |                 |          |                  |  |
| 14. FATHER'S NAME   |  |                      | 15. MOTHER'S MAIDEN NAME   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| John  |  |                      | Barth  |  | Pauline Smith  |   |                          |                                 |  |                  |                 |          |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                      | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |                          |                                 |  |                  |                 |          |                  |  |
| No  |  |                      | 225-12-4263D   |  | Mrs. Charles Bosley  |   |                          |                                 |  |                  |                 |          |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| PART I. DEATH WAS CAUSED BY:  |  |                      | 4 months   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| IMMEDIATE CAUSE (a) Widespread metastatic parotid carcinoma   |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 1420  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| (b)   |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| (c)   |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 1420  |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 19a. DATE OF OPERATION  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |                          |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                  |                 |          |                  |  |
|   |  |                      |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                          |                                 | YES  |                  |                 |          |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                      | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                          |                                 |  |                  |                 |          |                  |  |
|   |  |                      | HOUR A.M. Month Day Year   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 21d. INJURY OCCURRED  |  |                      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION   |                          |                                 |  |                  |                 |          |                  |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                      |  |  |  | Street or R.F.D. No. City or Town County State  |                          |                                 |  |                  |                 |          |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1968, to 8/8, 1968, that (I) (we) last saw the deceased alive on 8/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                      |  |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 22b. SIGNATURE  |  |                      | 22c. DATE SIGNED   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| Charles C. Brown, M.D.  |  |                      | 8/9/68   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                      | 22e. ADDRESS   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| Charles C. Brown, M.D.  |  |                      | 6701 N. Charles Street   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                      | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |                          | 23d. LOCATION (City or Town)    |  | (County) (State) |                 |          |                  |  |
| Burial - Rem.   |  |                      | Aug. 12, 1968  |  | Blandford  |   |                          | Petersburg,                     |  | Va.              |                 |          |                  |  |
| 24. FUNERAL DIRECTOR  |  |                      | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |                          |                                 |  |                  |                 |          |                  |  |
| H.W. Jenkins & Sons Co.   |  |                      | 4905 York Road   |  |  | Charles Judge   |                          |                                 |  |                  |                 |          |                  |  |
| Balto. 12, Md.  |  |                      | DATE AUG 12 1968   |  |  |   |                          |                                 |  |                  |                 |          |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Joshua Frank Brown Jr.</b>   |  |   | 2a. DATE OF DEATH<br>Month 8 Day 7 Year 68  |   | 2b. HOUR<br>P M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br><b>Jan. 26, 1908</b>  |   | 6. AGE (In years lost birthday)<br><b>60</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8164 Loch Raven Blvd.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Clerical Work</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 | 13e. STREET AND NUMBER<br><b>8164 Loch Raven Blvd.</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph Frank Brown</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Esma A. Brown</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-7849</b>  | 17. INFORMANT Address<br><b>Margaret Brown Same</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Paroxysmal Atrial Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Arteriosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) <del>(the physician)</del> attended the deceased from <b>1962</b> , 19 <b>8-7-68</b> , to <b>8-7-68</b> , that (I) <del>(we)</del> lost the deceased alive on <b>8-7-68</b> 19 <b>19</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>M. Paul Byerly</b>  |  | DEGREE<br><b>MD.</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>Aug. 8, 1968</b>                              |
| 22d. PHYSICIAN'S NAME (Type)<br><b>M. Paul Byerly MD.</b>  |  | 22e. ADDRESS<br><b>5820 York Road Baltimore Maryland</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>8/10/68.</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 9 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |  |                        |                                   |  |
|--|---------|------------------------------|--|--|---|--|------------------------|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |   |  |                        |                                   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH  |                        | 2b. HOUR                          |  |
| William Broyer   |         |                              |  |  |   | Aug. 6 68  |                        | 7:20a                             |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years)  | 7. IF UNDER 1 YEAR   | 8. IF UNDER 24 HRS  | 2c. DATE PRONOUNCED DEAD   |                        | 2d. HOUR                          |  |
| Male   | White   | Aug. 6, 68                   | 78   | MONTHS   | DAYS  | Month Aug Day 6 Year 68  |                        | 8:00                              |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                        |                                   |  |
| Laurence Mass.   |         | U.S.A.                       |  |  |   | Baltimore Md.  |                        |                                   |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                        | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Catonsville  |         |                              | Shangri Nursing Home   |  |   | Retired Conn. Optical Co.  |                        |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>      | 13e. STREET AND NUMBER |                                   |  |
| Md.  |         |                              | Balto.   |  | Randallstown  | X  | 3605 Templar Rd.       |                                   |  |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |   |  |                        |                                   |  |
| First Middle Last  |         |                              | First Middle Last  |  |   |  |                        |                                   |  |
| Napoleon Broyer  |         |                              | Odus I. Holt   |  |   |  |                        |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |                        |                                   |  |
| WWI  |         |                              | WWI  |  | Mrs. Carroll J. Kite 3605 Templar Rd. 21133                                     |  |                        |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |   |  |                        |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |         |                              |  |  |   |  |                        |                                   |  |
| IMMEDIATE CAUSE (a) Pulmonary Emboli Sudden  |         |                              |  |  |   |  |                        |                                   |  |
| 887x DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |   |  |                        |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Right Hip 3 wks   |         |                              |  |  |   |  |                        |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |         |                              |  |  |   |  |                        |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |   |  |                        |                                   |  |
| 9047 Generalized Arteriosclerosis  |         |                              |  |  |   |  |                        |                                   |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20. AUTOPSY?   |                        |                                   |  |
| 18 JULY 68   |         |                              | Fracture of Rt Hip Open Reduction Swett Hall                                 |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                        |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                        |                                   |  |
|  |         |                              | HOUR A.M. P.M. July 16 68  |  | Fell in Room in Nursing Home  |  |                        |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |                        |                                   |  |
|  |         |                              | Nursing Home Shangri Nursing Home  |  | 333 Hartman Ave Catonsville   |  |                        |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |  |                        |                                   |  |
| ACTUAL SIGNATURE   |         |                              | EXAMINER'S NAME (Type)   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                        | 22b. DATE SIGNED                  |  |
| Charles F. O'Donnell   |         |                              |  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                    |                        | 8/7/68                            |  |
|  |         |                              |  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                            |                        |                                   |  |
|  |         |                              |  |  |   | ADDRESS (Street, city, town, or county)  |                        |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |                        |                                   |  |
| Burial   |         | Aug. 6, 68                   |  | Baltimore National   |   | Baltimore Md.  |                        |                                   |  |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |  |   | 25a. REC'D BY REGISTRAR  |                        | 25b. REGISTRAR'S SIGNATURE        |  |
| Loring Byers 8728 Liberty Rd. Randallstown Md. 21133   |         |                              |  |  |   | DATE AUG 9 1968  |                        | Charles Judge                     |  |

11023

William Proyer  
Kale White  
Aug. 6, 1908

Lawrence Mass. U.S.A.

Belleville  
Shanty Building House  
Belleville  
Belleville  
Belleville  
Belleville

Oct 1, 1911

Shanty Building

777-10-1007  
The Carroll & Alice Jones Temple Rd. 11023

Belleville  
Belleville  
Belleville

Belleville  
Belleville  
Belleville

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |   |                                   |  |
|--|--|--|--|--|---|---|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |   |                                   | 2b. HOUR                                     |
| Marie  |  |  | Brunckhorst  |  |   | Month Day Year  |   |                                   | 8 30 A.M.                                    |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS       |  |
| Female   |  | white  |  | Aug 8, 1877  |   | 21 91 YRS.  |   | IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                   |  |
| Sweden   |  | U.S.A.   |  |  |   | Baltimore County Md.  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Catonsville  |  |  | Spring Grove State Hospital  |  |   | Housewife   |   |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Baltimore  |  | Baltimore   |   | NO <input checked="" type="checkbox"/>  |                                   | 101 South Prospect Ave.                      |
| 14. FATHER'S NAME  |  |  | Last   |  |   | 15. MOTHER'S MAIDEN NAME  |   |                                   | First Middle Last                            |
| (dec's) Daniel   |  |  | Nelson   |  |   | Annie   |   |                                   | ?  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT Address   |   |                                   |  |
| No   |  |  | None   |  |   | Records: Spring Grove State Hospital  |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |   |                                   |  |
| IMMEDIATE CAUSE (a) 481x Left Lower lobe pneumonia   |  |  |  |  |   |   |   |                                   | 5 days                                       |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |   |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |   |                                   |  |
| (c)  |  |  |  |  |   |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |   |                                   |  |
| 490x A.S.C.V.D. = heart failure.   |  |  |  |  |   |   |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |  |
|  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |                                   |  |
|  |  | HOUR A.M. Month Day Year   |  |  |   |   |   |                                   |  |
|  |  | P.M. 19  |  |  |   |   |   |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |                                   |  |
|  |  |  |  |  |   |   |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 15, 1968, to , 19 , that (I) (we) last saw the deceased alive on 8/10/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |   |                                   |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED                             |
| Monida L. Travelle   |  |  |  |  |   |   |   |                                   | 8/10/68                                      |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |   |   |                                   |  |
|  |  |  |  |  | Spring Grove State Hospital   |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |   |                                   |  |
| Burial   |  | 8/13/68  |  | Maple Grove Cemetery   |   | New Gardens New York  |   |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE  |                                   |  |
| Leonard J Ruck Inc Baltimore, Maryland   |  |  |  |  | AUG 12 1968   |   | [Signature]   |                                   |  |

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TRANSPORTATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>RAY</b> <b>E</b> <b>Buckheit</b>   |  |   |   |   |  | 2a. DATE OF DEATH<br>Month <b>8</b> - Day <b>3</b> - Year <b>68</b>  |   |   | 2b. HOUR<br><b>5:30 A M</b>  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>                           |   | 5. DATE OF BIRTH<br><b>1-17-93</b>  |  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                     |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLS TOWN</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTO. CO. GEN. HOSP</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                            |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>                       |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  |   | 13b. COUNTY<br><b>--</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>3012 Ferndale Ave</b>                   |  |   |  |
| 14. FATHER'S NAME First <b>George</b> Middle <b>Richard</b> Last <b>Carr</b>  |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Alice</b> Last <b>Daniels</b>   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>218-07-3201B</b>   |  | 17. INFORMANT<br><b>Eugene R. Buckheit</b>   |   |   | Address<br><b>3012 Ferndale Ave.</b>                                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |  |  |   |   |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |   |   |  |  |   |   |  |  |   |  |
| IMMEDIATE CAUSE (a) <b>Intractable Congestive Heart Failure</b>   |  |   |   |   |  |  |   |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |  |   |   |  |  |   |  |
| (b) <b>Arteriosclerotic Cardiovascular Disease</b>  |  |   |   |   |  |  |   |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |  |   |   |  |  |   |  |
| (c) <b>7 years</b>  |  |   |   |   |  |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>  |  |   |   |   |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-3-68</b> , 19 <b>68</b> , to <b>8-3-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-3-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Jesus G. Santano M.D.</b>  |  |   |   |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>8-3-68</b>                                    |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Jesus G. Santano</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>5401 Old Court Road</b>   |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>8-6-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western</b> |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>6. Howard Strong</b>   |  |   |   |   |  | ADDRESS<br><b>3207 W. North Ave.</b>   |   |   | 25. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                    |  |   |  |
| DATE<br><b>AUG 6 1968</b>   |  |   |   |   |  | DATE<br><b>AUG 6 1968</b>  |   |   |  |  |   |  |

11025

DEPARTMENT OF STATE

11025

Mary Alice Franklin

George Richard Davis

210-1-3013 Eugene E. Nichols 3013 Franklin Ave.

no

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| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |        |      |  |  |  |   |
|---|---------|--|--|--------|------|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |        |      |  |  |  |   |
| CERTIFICATE OF DEATH  |         |  |  |        |      |  |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First  | Middle | Last | 2a. DATE OF DEATH<br>Month Day Year  |  |  | 2b. HOUR AM                                   |
| Mary E. Butler  |         |  |  |        |      | August 5, 1968   |  |  | 11:28 AM                                      |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |        |      | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |   |
| F   | W       |  | December 16, 1886  |        |      | 81 YRS.  |  |  |   |
| 7a. BIRTHPLACE (State or foreign country)   |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |        |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |
| Baltimore, Md.  |         |  | U.S.A.   |        |      |  |  | Baltimore Md.  |   |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |   |
| Towson  |         |  | Dulaney Towson Nursing Home  |        |      | Housewife  |  | Own Home   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. CITY OR TOWN  |        |      | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER   |   |
| Md.   |         |  | Baltimore Balto. 12  |        |      |  |  | 229A Rogers Forge Road   |   |
| 14. FATHER'S NAME   |         |  | First  | Middle | Last | 15. MOTHER'S MAIDEN NAME   |  |  | First Middle Last                             |
| Edmund Burke Moore  |         |  |  |        |      | Anna Eliza Hallman   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |         |  | 16b. SOCIAL SECURITY NO.   |        |      | 17. INFORMANT  |  |  | Address                                       |
| No  |         |  | 218-03-5928A   |        |      | William B. Stansbury, Jr.  |  |  | 405 Mercantile Tr. Bldg.                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |        |      |  |  |  |   |
| PART I. DEATH WAS CAUSED BY:  |         |  |  |        |      |  |  |  |   |
| IMMEDIATE CAUSE (a) <u>Acute heart failure.</u>   |         |  |  |        |      |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Hypertensive degenerative C.V. Disease</u>   |         |  |  |        |      |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Arthritis deformans</u>  |         |  |  |        |      |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |  |        |      |  |  |  |   |
| 443X  |         |  |  |        |      |  |  |  |   |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
|   |         |  |  |        |      |  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |
|   |         |  |  |        |      |  |  |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |
|   |         |  |  |        |      |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 Mar.</u> , 19 <u>67</u> , to <u>5 Aug.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>5 Aug.</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |        |      |  |  |  |   |
| 22b. SIGNATURE  |         |  | 22c. DATE SIGNED   |        |      |  |  |  |   |
| Joseph E. Muse, Jr.   |         |  | 5 Aug '68  |        |      |  |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)  |         |  | 22e. ADDRESS   |        |      |  |  |  |   |
| Joseph E. Muse, Jr.   |         |  | 2725 N. Charles St.  |        |      |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |  | 23b. DATE  |        |      | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State) |
| Burialment  |         |  | 8-7-68   |        |      | Lorraine Mausoleum   |  |  | Woodlawn, Balto. Co., Md.                     |
| 24. FUNERAL DIRECTOR  |         |  |  |        |      | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |   |
| H.W. Jenkins & Sons Co.   |         |  |  |        |      | 4905 York Road   |  | 25b. REGISTRAR'S SIGNATURE   |   |
| Balto. 12, Md.  |         |  |  |        |      |  |  | AUG 6 1968   |   |

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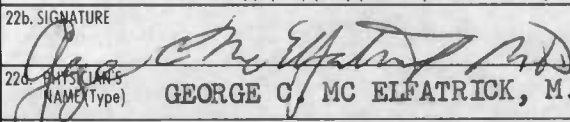

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## CERTIFICATE OF DEATH

|  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EDWARD</b>  |  |  | First Middle Last <b>L. BYRD</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>5</b> Year <b>68</b>   |  |  | 2b. HOUR<br><b>6:30 P M</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>NEGRO</b>   |  |  | 5. DATE OF BIRTH<br><b>4/29/13</b>  |  |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>MACHINE OPERATOR</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MACHINE CO.</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |
| 13e. STREET AND NUMBER<br><b>1831 W. Baltimore, Street</b>   |  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>EDWARD BYRD</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>VIRGINIA HOGAN</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give year or dates of service) <b>WW II</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215 07 75 75</b>   |  |  | 17. INFORMANT<br>Address<br><b>CLIN.RECORDS, AVA HOSPITAL, FT HOWARD, MD.</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>444.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>454 X</b><br>(b) <b>THROMBOSIS AORTIC PROSTHESIS WITH GANGRENE STUMP OF RIGHT LEG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>ARTERIOSCLEROTIC HEART DISEASE</b>  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>6/20/68</b> , 19__, to <b>8/5/68</b> , 19__, that (X) (we) lost saw the deceased alive on <b>8/15/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><br>22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M.D.</b>  |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br><b>8/6/68</b>   |  |  |
| 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |  |   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>8-9-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>MORTEN &amp; DYETTE FUNERAL HOME</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>AUG 7 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |

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11057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-68  
30M REV. 1-68

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 11050  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                |  | 11058   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Sr. Joseph Pierre, O.S.F. (Cain)</b>  |  |  |  | 2a. DATE OF DEATH<br><b>8</b> Month <b>26</b> Day <b>68</b> Year  |  | 2b. HOUR<br><b>4:15pm</b>   |  |  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>April 8, 1918</b>  |  | 6. AGE (In years<br>last birthday) <b>50</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, or if retired) <b>Religious</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7620 York Rd. 21204</b> |  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Lester Cain.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Julia Sharps.</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>St. Joseph's Hospital.</b>  |  | Address<br><b>Towson, Md.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>7484</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Polycystic Kidneys</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>7521</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 12, 19 68</b> , to <b>August 26, 19 68</b> , that (I) (we) last<br>saw the deceased alive on <b>August 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Lawrence F. Misanik</i>   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>8-26-68</b>  |  |  |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Lawrence F. Misanik M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8/29/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, inc. 5305 Harford Rd.</b>  |  |  |  | ADDRESS   |  | 25a. REGD BY REGISTRAR<br><b>AUG 27 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John A. Judge</i>   |  |   |  |

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RECEIVED

Mr. Joseph H. ... (cont.)

April 1, 1915

White

Female

and Virginia ...

St. Joseph Hospital

Woman

Townson

Maryland

John ...

John ...

St. Joseph Hospital

April 1, 1915

White

Female

John ...

7/2/15

John ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |                  |  |      |  |                   |
|--|--|--|--------------------------|---|------------------|--|------|--|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |                  |  |      |  |                   |
| CERTIFICATE OF DEATH   |  |  |                          |   |                  |  |      |  |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle  | Last             | 2a. DATE OF DEATH<br>Month Day Year  |      |  | 2b. HOUR P        |
| Thomas   |  |  | Alphonsus                | Carol   | August           | 31   | 1968 | 10:30  | M                 |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |                  | 6. AGE (In years last birthday)  |      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |                   |
| Male   |  | White  |                          | Dec. 16, 1895   |                  | 72   |      |  |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH   |      |  |                   |
| Maryland   |  | United States  |                          |   |                  | Baltimore Md.  |      |  |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |      |  |                   |
| Towson   |  | St. Joseph's Hospital  |                          | Balto. City Police Dept.  |                  |  |      |  |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      | 13e. STREET AND NUMBER                       |                   |
| Maryland   |  | Baltimore  |                          | Baltimore   |                  |  |      | 1446 Gittings Ave.- 21212                    |                   |
| 14. FATHER'S NAME  |  |  | First                    | Middle  | Last             | 15. MOTHER'S MAIDEN NAME   |      |  | First Middle Last |
| Edward   |  |  | Carol                    | Ann   | McGovern         |  |      |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes/no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT    |  |      | Address                                      |                   |
| Yes  |  |  | 220-36-3258              |   | Thomas M Carolan |  |      | Same   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhagic shock</u><br><u>287.1</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Gastro-intestinal hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Thrombocytopenia</u> |  |  |                          |   |                  |  |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)  |  |  |                          |   |                  |  |      |  |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          | 20a. AUTOPSY?   |                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |      |  |                   |
| 8/30/68  |  | Gastro-intestinal bleeding   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  |  |      |  |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                  |  |      |  |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                  |  |      |  |                   |
|  |  |  |                          |   |                  |  |      |  |                   |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>68</u> , to <u>August 31</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>August 31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                          |   |                  |  |      |  |                   |
| 22b. SIGNATURE   |  |  |                          | 22c. DATE SIGNED  |                  |  |      |  |                   |
| <u>Reynaldo Orjuela-Gomez, M.D.</u>  |  |  |                          | 9/1/68  |                  |  |      |  |                   |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |                          | 22e. ADDRESS  |                  |  |      |  |                   |
|  |  |  |                          | 7620 York Rd. Towson, 4, Md.  |                  |  |      |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION (City or Town) (County) (State)  |      |  |                   |
| Burial   |  | 9/4/68   |                          | Baltimore National  |                  | Baltimore, Maryland  |      |  |                   |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |                          | 25a. REC'D BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE   |      |  |                   |
| Leonard J Ruck Inc   |  | Baltimore, Md  |                          | DATE SEP 3 1968   |                  | f Charles Juge   |      |  |                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 11052  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |  |   |  | 11060   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>CHARLES</b>  |  | Middle<br><b>E.</b>   |  | Last<br><b>CARROLL</b>  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>30</b> Year <b>68</b>                      |  | 2b. HOUR<br><b>2:55AM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>7/21/11</b>  |  | 6. AGE (In years<br>last birthday)<br><b>57</b>   |  | IF UNDER 1 YEAR<br>MONTHS<br>YRS.   |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>BALTIMORE, MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VET. ADM. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>PEST CONTROLLER</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>EXTERMINATING</b>                                    |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7092 BRIDGE AVENUE</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>First<br><b>WILLIAM</b>   |  | Middle<br><b>ALBERT</b>  |  | Last<br><b>CARROLL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>ELSIE</b>   |  | Middle<br><b>S.</b>   |  | Last<br><b>NEARMAN</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>188X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last <b>1810</b><br>(b) <b>CARCINOMA, URINARY BLADDER WITH METASTASES TO LYMPH NODES,</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>PROSTATE AND PELVIC WALL,</b><br>(c) <b>OLD</b>      |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>RECENT</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC PYELONEPHRITIS WITH UROLITHIASIS, RT. OLD.</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br><b>YES</b> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/5/68</b> , 19____, to <b>8/30/68</b> , 19____, that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>8/30/68</b> , 19____, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>[Signature]</b>   |  | ATTENDING<br>PHYS.<br><input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>8/30/68</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>KRISHNA V. S. RAO, M. D.</b>  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>9-3-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>   |  | ADDRESS<br><b>CVACH FUNERAL HOME</b>   |  | 25a. DATE BY REGISTRAR<br><b>SEP 3 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |
|  |  |  |  | DATE<br><b>21237</b>  |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 116 (4)  
30M REV 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 11053  |  | CERTIFICATE OF DEATH  |  |   |  |  |  | 11061   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LILLIE MAE CARTER</b>  |  |   |  |   | 2a. DATE OF DEATH<br><b>AUGUST 30, 1968</b>  |  |  | 2b. HOUR<br><b>1:15</b> M                                       |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Colored</b>   |  | 5. DATE OF BIRTH<br><b>July 23, 1921</b>  |  | 6. AGE (In years last birthday)<br><b>47</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GR. BALTO. MED. CENTER</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Domestic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2902 Allendale Rd.</b>             |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Hickenbottom</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Irene ?</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Virginia Elliott 2902 Allendale Rd.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA TONGUE WITH METASTASIS</b><br><b>1419</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>MARKED DEHYDRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1419 NONE</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-25</b> , 19 <b>68</b> , to <b>8-30</b> , 1968, that (I) (we) last saw the deceased alive on <b>8-30</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Andrew Chen</i>   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8-30-68</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ANDREW CHEN, MD</b>   |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST.</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>SEP. 3, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Calvary Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cedar Hill Md.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Williams Funeral Home</b>   |  | ADDRESS<br><b>3199 Schroeder St.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 4 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>  |  |   |  |

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~page 3~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11054   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11062  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| John Millard CHALK, Sr.   |  |  |  |  |  |  |  |  |  | 8 Month 8 Day 68 Year  |  |  |  |  |  |  |  |  |  | 4:45 P.M.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR        |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| MALE  |  |  |  |  |  |  |  |  |  | Cau  |  |  |  |  |  |  |  |  |  | 10/15/1892   |  |  |  |  |  |  |  |  |  | 75 YRS.   |  |  |  |  |  |  |  |  |  | MONTHS                 |  |  |  |  |  |  |  |  |  | DAYS             |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |  |  |  |  |  | Md.                    |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |  |  |  |  |  |  |  |  | Greater Balto. Med. Center   |  |  |  |  |  |  |  |  |  | Plumber  |  |  |  |  |  |  |  |  |  | Residential   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | -  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 2005 Oakington St.     |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| John H. Chalk   |  |  |  |  |  |  |  |  |  | Rose Gill  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 216 07 6419  |  |  |  |  |  |  |  |  |  | John M. Chalk Jr.  |  |  |  |  |  |  |  |  |  | 4016 BRAUNOVISTA AVE  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | 1621   |  |  |  |  |  |  |  |  |  | 1621   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| (b)   |  |  |  |  |  |  |  |  |  | Carcinoma of lung  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 163X  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | YES   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | City or Town  |  |  |  |  |  |  |  |  |  | County                 |  |  |  |  |  |  |  |  |  | State            |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1968, to 8/8, 1968, that (I) (we) last saw the deceased alive on 8/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | Charles C. Brown   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED       |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 8/9/68                 |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | Charles C. Brown, M.D.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  | 6701 N. Charles Street  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |  |  |  |  |  |  |  | 8-12-68  |  |  |  |  |  |  |  |  |  | Copley Grove   |  |  |  |  |  |  |  |  |  | Cockeysville, Md.   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | Burger Funeral Home, Baltimore   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | William R. Heister   |  |  |  |  |  |  |  |  |  | DATE AUG 13 1968   |  |  |  |  |  |  |  |  |  | Charles Judge   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |

11005

LIBRARY OF CONGRESS



11005



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11055   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 11063                       |  |  |  |  |                             |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Tenney Cornelius Chew</i>  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br><i>Aug. 31 68</i>   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br><i>2 p M</i>    |  |  |  |  |                             |  |  |  |  |
| 3. SEX<br><i>Male</i>   |  |  |  |  | 4. RACE<br><i>Negro</i>   |  |  |  |  | 5. DATE OF BIRTH<br><i>5-15-14</i>  |  |  |  |  | 6. AGE (In years last birthday)<br><i>54</i> YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Ind.</i>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><i>Baltimore County</i> Md.  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Mt. Wilson</i>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Mt. Wilson State Hosp.</i> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Ind.</i>  |  |  |  |  | 13b. COUNTY<br><i>Calverton</i>   |  |  |  |  | 13c. CITY OR TOWN<br><i>Lower Marlboro</i>  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Gurley Chew</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Katie Auffel</i>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)<br><i>No</i>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>214-14-3948</i>  |  |  |  |  | 17. INFORMANT Address<br><i>Records, Mt. Wilson State Hospital</i>  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Far Advanced pulmonary</i><br><i>011.2</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tuberculosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>15 mo.</i>   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>0021</i>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 20, 19 67</i> to <i>Aug. 31, 19 68</i> , that (I) (we) last saw the deceased alive on <i>Aug. 31</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE<br><i>W Newcomer</i>   |  |  |  |  |   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  |  | 22c. DATE SIGNED<br><i>8-31-68</i>   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>William Newcomer, M.D.</i>   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><i>Mount Wilson, Maryland</i>   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |  |  |  | 23b. DATE<br><i>9-4-68</i>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ches. Lower Marlboro</i>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Lower Marlboro Cal Md.</i>               |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Leroy Berry - Huntington</i>   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br><i>SEP 5 1968</i>  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |

14083

WEST-ALICE BROWN

SEP 2 1968

(M)

(G)

14083

(C)

SEP 2 1968  
WEST-ALICE BROWN  
14083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |                          |   |   |   |                     |
|--|--|--|--------------------------|---|---|---|---------------------|
| 11056  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                        |                          |   |   | 11064   |                     |
| CERTIFICATE OF DEATH   |  |  |                          |   |   |   |                     |
| 1. DECEASED-NAME<br>(Type or print)  |  | First Philip   | Middle <del>Philip</del> | Last JAMES F. CHILCOAT  | 2a. DATE OF DEATH<br>Month 8 Day 26 Year 68 |   | 2b. HOUR<br>2:30A M |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |                          | 5. DATE OF BIRTH<br>12/22/98  |   | 6. AGE (In years last birthday)<br>28 69 YRS.   |                     |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE, Md.  |                     |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VET. ADM. HOSPITAL |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>BOTTLER  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>DAIRY  |                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |                          | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |
| 14. FATHER'S NAME First Middle Last<br>WILLIAM A. CHILCOAT   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>EMMA J. PARSONS                                      |                          | 13e. STREET AND NUMBER<br>8710 LITTLEWOOD ROAD  |   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) YES  |  | 16b. SOCIAL SECURITY NO.<br>WW II  |                          | 17. INFORMANT<br>Address<br>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.  |   |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 593.2 PULMONARY INFARCT<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 603.2 (b) BILATERAL BRONCHOPNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF (c) KIDNEY INFARCT |  |  |                          |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>MYOCARDIAL INFARCTION OLD. LEFT CEREBRAL VASCULAR ACCIDENT (RIGHT HEMIPLEGIA)   |  |  |                          |   |   |   |                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                     |                     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |                     |
| 22a. I certify that (X) (this hospital) attended the deceased from 4/15/68, 19__, to 8/26/68, 19__, that (X) (we) lost saw the deceased alive on 8/26/68, 19__, and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) did (did not) view the body after death.   |  |  |                          |   |   |   |                     |
| 22b. SIGNATURE<br>Erhard J. Bunyor M.D.  |  |  |                          | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED<br>8/26/68   |                     |
| 22d. PHYSICIAN'S NAME (Type)<br>ERHARD J. BUNYOR, M. D.  |  |  |                          | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND   |   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>8/29/68   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE CEMETERY  |   | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |                     |
| 24. FUNERAL DIRECTOR<br>RUCK FUNERAL HOME<br>HARFORD ROAD, BALTIMORE, MARYLAND   |  |  |                          | 25a. DATE OF REQUISITION<br>AUG 27 1968   |   | 25b. REQUISITION SIGNATURE<br>[Signature]   |                     |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ <sup>insert</sup> carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 11057   |  | MARTLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 11065   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Floyd G Childs   |  |  | 2a. DATE OF DEATH<br>Month 8 Day 15 Year 68 |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>7-7-04  |  | 6. AGE (In years<br>last birthday)<br>64 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Balto  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) Balto Co Gen Hosp                  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE Md.  |  | 13b. COUNTY Balto  |   | 13c. CITY OR TOWN Balto   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br>Guy Childs   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ida Ruff   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br>Balto Co Gen Hosp Randallstown Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Oat cell Carcinoma metastasizing to liver<br>1621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 yr.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>1621   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>8/10/68   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GI Hemorrhage 2° Ca.   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? No.                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 7, 1968, to Aug 15, 1968, that (I) (we) last<br>saw the deceased alive on Aug 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>L Solomon MD  |  | DEGREE   |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                       |  | 22c. DATE SIGNED<br>8/15/68.  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>L Solomon  |  |  |   | 22e. ADDRESS<br>3600 LOCHearn DR.   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>Aug. 19, 68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn Maryland                              |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers 8728 Liberty Road Md. 21133  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE AUG 19 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge   |  |

11002

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

WASHINGTON, D. C.

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Woodward Clyde

Woodward Clyde

Aug. 19, 68

Letter

11002

11002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |  |  |
|--|--|--|--|---|---|---|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)<br><b>Sr. Mary Godfrey, OSF</b>  |  |  | First Middle Last<br><b>(CHURCH)</b>                               |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>AUGUST 27 1968</b>  |  |  | 2b. HOUR<br><b>11:00 PM</b>                  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>OCTOBER 15, 1891</b>   |   | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Massachusetts</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Religious</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>2511 E. Preston St. #21213</b>      |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Joseph Church</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mary Mahon</b> |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br>Address<br><b>Sr. Rose Rita St Katherine's Convent</b>   |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Esophagus</b><br><b>150 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intestinal Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Intestinal Obstruction</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>150 X</b> |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 17, 1968</b> , to <b>August 27, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>J. Banderas</b>   |  |  |  | DEGREE<br><b>JULIO BANDERAS</b>   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>August 27, 1968</b>                       |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JULIO BANDERAS</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Road Towson, Md. #21204</b>  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/31/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Balto. Md.</b>   |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 28 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11059

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11067

|  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
|--|--|---------|-------------------|--|--|--|--|--|----------------|-----------------------------|--|--|--|------------|--|----------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |         | First Middle Last |  |  | 2a. DATE KNOWN OF DEATH  |  |  | Month Day Year |                             |  | 2b. HOUR   |  |            |  |                            |  |  |  |
| EDWARD   |  |         | G.                |  |  | CLINGMAN   |  |  | X UNK 19       |                             |  | UNK  |  |            |  |                            |  |  |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS  |                | IF UNDER 24 HRS. HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR   |  |                            |  |  |  |
| male   |  | white   |                   | Sept. 28 96  |  | 75 1 YRS.  |  |  |                |                             |  | August 19  |  | 5:15 P. M. |  |                            |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                             |  | 9. COUNTY OF DEATH   |  |            |  |                            |  |  |  |
| Baltimore Co. Md. U.S.A.   |  |         |                   |  |  |  |  |  |                |                             |  | Baltimore Md.  |  |            |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                |                             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |            |  |                            |  |  |  |
| Towson   |  |         |                   | Greater Baltimore Medical  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         |                   | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |                |                             |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |            |  | 13e. STREET AND NUMBER     |  |  |  |
| Maryland   |  |         |                   | Baltimore  |  |  |  | Towson   |                |                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |            |  | 301 Bosley Avenue          |  |  |  |
| 14. FATHER'S NAME  |  |         |                   | First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME   |                |                             |  | First Middle Last  |  |            |  |                            |  |  |  |
| George Clingman  |  |         |                   |  |  |  |  | Laura Delker   |                |                             |  |  |  |            |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |         |                   | (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.   |                |                             |  | 17. INFORMANT  |  |            |  |                            |  |  |  |
| Yes.   |  |         |                   | W.W.I.H.   |  |  |  | 214 20 7264  |                |                             |  | Roland C. Clingman, 1905 Forest Park Ave. Baltimore, Md.                                     |  |            |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |                   |  |  |  |  |  |                |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |            |  |                            |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| (c)  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 4221   |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  |         |                   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |  |                |                             |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |            |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |                   |  |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.                          |  |  |                |                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |            |  |                            |  |  |  |
|  |  |         |                   |  |  | 19   |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |                   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |                |                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |            |  |                            |  |  |  |
|  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| ACTUAL SIGNATURE   |  |         |                   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |  |                |                             |  | 22b. DATE SIGNED   |  |            |  |                            |  |  |  |
| EXAMINER'S NAME (Type)   |  |         |                   |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>               |  |  |                |                             |  | 8/20/68  |  |            |  |                            |  |  |  |
| Werner U. Spitz, M.D.  |  |         |                   |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                             |  |  |                |                             |  | ADDRESS (Street, city, town, or county)  |  |            |  |                            |  |  |  |
|  |  |         |                   |  |  |  |  |  |                |                             |  |  |  |            |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         |                   | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                |                             |  | 23d. LOCATION (City or Town) (County) (State)  |  |            |  |                            |  |  |  |
| Burial   |  |         |                   | Aug. 22, 1968  |  |  |  | Dulaney Valley   |                |                             |  | Cockeysville, Md.  |  |            |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |                   |  |  |  |  | ADDRESS  |                |                             |  | 25a. REC'D BY REGISTRAR  |  |            |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| Wm. Cook-Brooks Towson, Towson, Md.  |  |         |                   |  |  |  |  |  |                |                             |  | DATE AUG 21 1968   |  |            |  | J. Charles Judge           |  |  |  |

11087

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY

REPORT

NO. 1

1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |  |  |   |   |                                  |  |
|--|--|--|--------------------------|---|--|--|--|---|---|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |  |  |   |   |                                  |  |
| CERTIFICATE OF DEATH   |  |  |                          |   |  |  |  |   |   |                                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>J.</b>       |   | Middle<br><b>NORBERT</b>   |  | Last<br><b>COLL</b>  |   | 2a. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>30</b> Year <b>1968</b> |                                  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |                          | 5. DATE OF BIRTH<br><b>JUNE 26, 1890</b>  |  |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.                      |   | 2b. HOUR<br><b>1.20</b> M   |                                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                           |   | IF UNDER 24 HRS.<br>HOURS<br>MIN |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SUMMIT NURSING HOME</b> |                          |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED CLAIMS DEPT. B&amp;ORR</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |   |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |                          | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>CATHEDRAL &amp; MADISON ST</b> |   |                                  |  |
| 14. FATHER'S NAME<br>First<br><b>JOHN</b>  |  |  | Middle<br><b>COLL</b>    |   |  | Last<br><b>ANN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First<br><b>WALSH</b>                       |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO. |   |  | 17. INFORMANT<br><b>MR. JOHN J. CRUMLISH CATONSVILLE</b>   |  |   | Address<br><b>401 N. BEECHWOOD</b>                                      |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Art scl. cardio vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hr</b><br><b>5 yr</b> |  |  |                          |   |  |  |  |   |   |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221 none</b>  |  |  |                          |   |  |  |  |   |   |                                  |  |
| 19a. DATE OF OPERATION<br><b>none</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |   |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day<br>P.M. <b>19</b>   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |   |                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                          | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County  |   | State                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> , 19 <b>65</b> , to <b>8/30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |  |  |  |   |   |                                  |  |
| 22b. SIGNATURE<br><b>Maurice Feldman</b>   |  |  |                          |   |  | DEGREE<br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/30/68</b>                          |   |                                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MAURICE FELDMAN</b>   |  |  |                          |   |  | 22e. ADDRESS<br><b>6610 Cron County Blvr</b>   |  |   |   |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>9/2/68</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b> |   |   |                                  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. NEARS &amp; SON 805 N. CALVERT STREET</b>  |  |  |                          |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>          |   |                                  |  |

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## CERTIFICATE OF DEATH

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11069

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>William Louis COLWELL</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>1</b> Year <b>1968</b>                     |   |  | 2b. HOUR<br><b>12:30</b> PM  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>January 13, 1904</b>   |  | 6. AGE (In years last birthday)<br><b>64</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Butler</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fisher Body</b>                                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>3917 Wilkey Ave.</b>  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>First <b>Richard C.</b> Middle <b>Colwell</b> Last <b>Colwell</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary E.</b> Middle <b>Matthew</b> Last <b>Matthew</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>2 13-10-4820</b>  |  | 17. INFORMANT<br>Address <b>Sarah E. Colwell - 3917 Wilkie Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lungs with metastasis</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                          |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1968</b> , to <b>August 1, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>August 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Beatriz P. Dizon</b>  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>8/1/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Beatriz P. Dizon, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-3-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>John C. Miller Inc - 6415 Calais Rd. - 21206</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11062

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11070

|  |  |   |              |   |  |  |   |  |                                 |                                     |
|--|--|---|--------------|---|--|--|---|--|---------------------------------|-------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First        | Middle  | Lost   | 2a. DATE OF DEATH<br>Month <u>8</u> Day <u>6</u> Year <u>68</u>                      |   |  | 2b. HOUR <u>5:02</u> P <u>M</u> |                                     |
| JOHN   |  |   | THOMAS COMES |   |  |  |   |  |                                 |                                     |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN  |              | 5. DATE OF BIRTH<br>01/03/04  |  | 6. AGE (In years<br>lost birthday)<br>84 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS                          |                                 | IF UNDER 24 HRS.<br>HOURS MIN.      |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |   |  |                                 |                                     |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Great Baltimore Medical Center |              | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>welder  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>self-employ                                  |   |  |                                 |                                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |              | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>4642 Ridge Road          |                                 |                                     |
| 14. FATHER'S NAME<br>John A. Comes   |  |   | First        | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME<br>Mary Chetelat  |   |  | First Middle Lost               |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no  |  | (If yes give war or dates of service)   |              | 16b. SOCIAL SECURITY NO.<br>212-40-5941   |  | 17. INFORMANT<br>Rose M. Comes   |   | Address<br>4642 Ridge Road                         |                                 |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE &amp; CARDIAC ARREST</u><br><u>1621</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>CA OF LUNG WITH METASTASIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PARALYSIS OF LEFT SIDE</u> |  |   |              |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |                                 |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>163x</u>  |  |   |              |   |  |  |   |  |                                 |                                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |              |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                 |                                     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |                                 |                                     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |              | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |   | County State                                       |                                 |                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>68</u> , to <u>8/06</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>8/06</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |              |   |  |  |   |  |                                 |                                     |
| 22b. SIGNATURE<br><u>Dr. Meshkimpour</u>   |  | DEGREE  |              | ATTENDING<br>PHYS.  |  | MED.<br>DIRECTOR   |   | STAFF<br>PHYS. <input checked="" type="checkbox"/> |                                 | 22c. DATE SIGNED<br><u>08/06/68</u> |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>DR. MESHKIMPOUR   |  | 22e. ADDRESS<br>6701 NORTH CHARLES ST   |              | BALT, MD  |  |  |   |  |                                 |                                     |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>8/9/68   |              | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Joseph Cem.   |  | 23d. LOCATION (City or Town)<br>Balto.   |   | (County)<br>Co.                                    |                                 | (State)<br>Md.                      |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home   |  | ADDRESS<br>7401 Belair Road   |              | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 9 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. J. Judge</u>                                     |   |  |                                 |                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME<br>(Type or print)  |        |  |       | 2a. DATE OF DEATH  |      | 2b. HOUR   |      |
|--|--------|--|-------|--|------|--|------|
| First  | Middle | Last   | Month | Day  | Year | Hour   | Min. |
| HELENE K CONNELLY  |        |  | Aug.  | 27   | 1968 | 239  | M    |
| 3. SEX   |        | 4. RACE  |       | 5. DATE OF BIRTH   |      | 6. AGE (In years lost birthday)                                      |      |
| FEMALE   |        | WHITE  |       | 5-13-88  |      | 80 YRS.  |      |
| 7a. BIRTHPLACE (State or foreign country)  |        | 7b. CITIZEN OF WHAT COUNTRY?   |       | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH   |      |
| Md.  |        | U.S.A.   |       |  |      | BALTIMORE COUNTY Md  |      |
| 10. CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      | 12b. KIND OF BUSINESS OR INDUSTRY                                    |      |
| CATONSVILLE  |        | SUMMIT NURSING Home  |       | Book Keeper  |      | Auto Industry  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |        | 13b. CITY OR TOWN  |       | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      | 13d. STREET AND NUMBER   |      |
| Md.  |        | Balto.   |       |  |      | 1215 Washington Blvd.  |      |
| 14. FATHER'S NAME  |        | 15. MOTHER'S MAIDEN NAME   |       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |      | 16b. SOCIAL SECURITY NO.   |      |
| Charles J.   |        | Pauline P  |       |  |      | 213-03-6727  |      |
| 17. INFORMANT  |        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Cardiorespiratory failure |       | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |      | immediate  |      |
| Mrs Helen Kampe RT D3 Box 63   |        | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease   |       | unknown  |      |  |      |
|  |        | DUE TO, OR AS A CONSEQUENCE OF (c)   |       |  |      |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |        |  |       |  |      |  |      |
| 4221 Carcinoma of the bladder  |        |  |       |  |      |  |      |
| 19a. DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |      |
|  |        |  |       |  |      |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |        | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |  |      |
|  |        |  |       |  |      |  |      |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |        | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |       | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |  |      |
|  |        |  |       |  |      |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/21/68, 19__, to 8/27/68, 19__, that (I) (we) last saw the deceased alive on 8/21/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |        |  |       |  |      |  |      |
| 22b. SIGNATURE   |        |  |       | 22c. DATE SIGNED   |      |  |      |
| Cliff Ratliff, Jr., M.D.   |        |  |       | 8/27/68  |      |  |      |
| 22d. PHYSICIAN'S NAME (Type)   |        |  |       | 22e. ADDRESS   |      |  |      |
| Cliff Ratliff, Jr., M.D.   |        |  |       | 4605 Edmondson Avenue, Baltimore, Md., 2122  |      |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |        | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)                        |      |
| Burial   |        | 8/30/68  |       | Lorraine Park Cem.   |      | Woodlawn Md.   |      |
| 24. FUNERAL DIRECTOR   |        |  |       | 25a. REC'D BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE   |      |
| John F. Bowman & Son Inc. 901 Hollins  |        |  |       | AUG 28 1968  |      |  |      |

11371

UNITED STATES DEPARTMENT OF AGRICULTURE

STATIONER'S COPY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place, remove carbon copies, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <span>11064</span> <span>CERTIFICATE OF DEATH</span> <span>11072</span> </div>   |  |  |  |  |  |   |  |                                   |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |                                   | 2b. HOUR                                     |
| Joseph Carl CONNER  |  |  |  |  |  | Month Day Year<br>Aug. 5 1968   |  |                                   | 6:15 AM                                      |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)  |                                   | 7. IF UNDER 1 YEAR MONTHS DAYS               |
| Male  |  | white  |  | 8-2-23   |  |   | 45 YRS.  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |
| Md.   |  | U.S.A.   |  |  |  | Baltimore County Md.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Mt. Wilson  |  |  | Mt. Wilson State Hosp.   |  |  | Champlain   |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| Md.   |  |  | Baltimore  |  | Lansdowne  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 408 4th Ave                                  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |  |
| Leonard Conner  |  |  | Margaret Stein   |  |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |  |
|   |  |  |  |  | Records, Mt. Wilson State Hospital   |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Tuberculosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>(moderate advanced)</u>                        |  |  |  |  |  |   |  |                                   | 2 days<br>12 yrs                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |                                   |  |
| 0021  |  |  |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |
|   |  |  |  |  |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |   |  |                                   |  |
|   |  |  |  |  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |  |
|   |  |  |  |  |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 4, 1968</u> , to <u>Aug. 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug. 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |
| 22b. SIGNATURE <u>W Newcomer</u>  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>8-5-68</u>   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.   |  |  |  |  | 22e. ADDRESS Mount Wilson State Hospital   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION (City or Town) (County) (State)  |                                   |  |
| BURIAL  |  | 8-7-1968   |  | Loudon Park Cemetery   |  |   | Baltimore, Maryland  |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |
| Howard H. Hubbard, 4107 Wilkens Ave.  |  |  |  | 21229  |  | AUG 6 1968  |  | <u>Charles Judge</u>              |  |

11078

STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)  |  |  | First<br><b>Wilbert</b>  |  |  | Middle<br><b>Frank</b>  |  |  | Last<br><b>CONRAD</b>  |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>March 6, 1911</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>15</b> Year <b>1968</b>                      |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Underwriter, Supervisor, Insurance</b>                        |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>1313 Burleigh Rd.</b>   |  |  | 14. FATHER'S NAME<br>First<br><b>Conrad</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Phillipine</b>  |  |  | Last<br><b>Scheid</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>340-05-8825</b>   |  |  | 17. INFORMANT<br>Address<br><b>Mrs. Betty B. Conrad, Same as # 13</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Perforated gastric ulcer with hemorrhage and massive aspiration of gastric contents</b><br>5311<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>5401   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/5/68</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Perforated ulcer</b>                                |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that <b>A</b> (this hospital) attended the deceased from <b>8/4/</b> , 19 <b>68</b> , to <b>8/15/</b> , 19 <b>68</b> , that <b>A</b> (we) last saw the deceased alive on <b>8/15/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Christina Feliciano, M.D.</b>   |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  | 22c. DATE SIGNED<br><b>8/15/68</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Feliciano, M.D.</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Aug. 19, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Lutheran</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>La Grange, Cook Co., Illinois</b>        |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 19 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

11072

STATE OF OHIO

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |   |  |  |
|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>MARIE I. CONWAY</b>   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>27</b> Year <b>1968</b> |  | 2b. HOUR <b>3:30</b> M <b>PM</b>   |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b>   | 5. DATE OF BIRTH <b>7 Dec 1895</b>  | 6. AGE (In years last birthday) <b>72</b> YRS.   | 7c. DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>27</b> Year <b>1968</b>                                 |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |
| 10. CITY OR TOWN OF DEATH <b>BALTO-City 34</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2108 F Town Hill Rd</b>     |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Baltimore Balto. 34</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER <b>2108 F Town Hill Rd</b>  |
| 14. FATHER'S NAME First <b>Oscar</b> Middle <b>Strohmeier</b> Last <b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Frank J. Smith (same)</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Diastolic hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Under 7</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>443X</b>  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. <b>7537</b>   | City or Town <b>Baltimore</b> County <b>Baltimore</b> State <b>Md.</b>                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |  |
| ACTUAL SIGNATURE <b>John C. Hyle</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED <b>8-27-68</b>  |
| EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |
|  |  | ADDRESS (Street, city, town, or county) <b>7537 Baltimore</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE <b>8/31/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>                                       |
| 24. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>AUG 28 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |

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RECEIVED BY THE U.S. DEPARTMENT OF AGRICULTURE

U.S. DEPARTMENT OF AGRICULTURE

RECEIVED BY THE U.S. DEPARTMENT OF AGRICULTURE

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |   |  |  |       |
|--|--|--|--|---|--|---|---|--|--|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |   |  |  |       |
| 11067  |  |  |  |   |  |   |   |  |  |       |
| 11075  |  |  |  |   |  |   |   |  |  |       |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  |       |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |   |  | 2b. HOUR<br>P.M.                         |       |
| Nathalie   |  |  | Kelley   |   |  | Cook  |   |  | August 24, 1968                          | 10:38 |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |       |
| Female   |  | White  |  | January 21, 1891  |  |   | 77 YRS.   |  |  |       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. COUNTY OF DEATH  |  |  | Md.   |
| New York   |  | U.S.A.   |  |   |  |   | Baltimore,  |  |  |       |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY        |       |
| Towson   |  |  | Dulaney Towson Nursing H.  |   |  | Housewife   |   |  |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                   |       |
| Maryland   |  |  | Baltimore  |   | Ruxton   |   |   |  | 1510 Ruxton Rd.                          |       |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |  |   |   |  |  |       |
| James D.J. Kelley  |  |  | Isabel dep. Morrell  |   |  |   |   |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address   |   |   |  |  |       |
| no   |  |  |  |   | Jerrold K. Cook 1510 Ruxton Rd. 21204  |   |   |  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Emphysema</u><br>492X DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years |  |  |  |   |  |   |   |  |  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>5271 None  |  |  |  |   |  |   |   |  |  |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |       |
| None   |  |  |  |   |  |   |   |  |  |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |       |
|  |  |  |  |   |  |   |   |  |  |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |       |
|  |  |  |  |   |  |   |   |  |  |       |
| 22a. I certify that (I) (this hospital) attended the deceased from August, 1966, to August, 1968, that (I) (we) lost the deceased alive on August 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |       |
| 22b. SIGNATURE<br>L. Myrton Gaines Jr.   |  |  |  |   | DEGREE<br>ATTENDING PHYS.  |   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22c. DATE SIGNED<br>August 25, 1968      |       |
| 22d. PHYSICIAN'S NAME (Type)<br>L. MYRTON GAINES JR.   |  |  |  |   | 22e. ADDRESS<br>7800 York Rd.  |   |   |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |       |
| Burial   |  | 8/28/68  |  | Woodlawn Cemetery   |  |   | Bronx, New York   |  |  |       |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |       |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  |  |  |   | DATE   |   | AUG 27 1968 yCharles Judge  |  |  |       |

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CERTIFICATE OF DEATH

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|   |  |  |  |   |  |  |   |  |   |   |  |
|---|--|--|--|---|--|--|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>R. Paul Cooksey</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Year <b>1968</b>   |   |  | 2b. HOUR<br><b>10:30 P.M.</b>  |   |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>2/18/1910</b>  |  | 6. AGE (In years last birthday)<br><b>58</b> YRS.  |   | 7. UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | 8. UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Salesman</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mkt rep.</b>  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Lutherville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8709 Valleyfield Rd.</b> |   |  |
| 14. FATHER'S NAME<br><b>Lemuel T. Cooksey</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Marian H</b>  |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>Mrs. R. Paul Cooksey 8709 Valleyfield Rd</b>          |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, recurrent</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hrs</b><br><b>10 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 11, 1968</b> , to <b>Aug 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer</b>   |  |  |  | DEGREE<br><b></b>   |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>   |   | MED. DIRECTOR <input type="checkbox"/>           |   | STAFF PHYS. <input type="checkbox"/>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>FREDERICK J. VOLLMER</b>   |  |  |  | 22c. DATE SIGNED<br><b>Aug 5, 1968</b>  |  |  |   |  |   |   |  |
| 22e. ADDRESS<br><b>6100 YORK RD BALTIMORE 21212</b>   |  |  |  |   |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/10/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemt.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Md.</b>                            |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Mitchell Wiedefeld Home 6500 York Rd.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 12 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A151-10  
30M REV. 1-68

| 11069  |  |  |  |  |   |   |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |         |  |  |     |  |  |  | 11077 |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|---|--|--|---|---|--|---|---------|--|--|-----|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| Item #6, Film 403 8/16/68 km   |  |  |  |  |   |   |  |  |   | CERTIFICATE OF DEATH  |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>PATRICK</b>   |  |  |  |  | First <b>G.</b> Middle <b>G.</b> Last <b>CORCORAN</b> |   |  |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>12</b> Year <b>68</b>            |  |   |         |  | 2b. HOUR<br><b>8:10</b> am                         |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>M</b>   |  |  | 4. RACE<br><b>White</b>  |  |   | 5. DATE OF BIRTH<br><b>28 Sept. 1932</b>  |  |  | 6. AGE (In years last birthday)<br><b>36</b> yrs.   |   |  | IF UNDER 1 YEAR<br>MONTHS <b>3</b> DAYS <b>3</b>      |         |  | IF UNDER 24 HRS.<br>HOURS <b>10</b> MIN. <b>00</b> |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTO., MD.</b>  |   |  |   |         |  |  | Md. |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO., MD. CENTER (Vender)</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Kennicott, Co</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Kennicott, Co</b>   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>  |  |  | 13b. COUNTY<br><b>BA, Co.</b>  |  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><b>117 First Ave. South</b> |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>John</b>   |  |  | Middle <b>James</b> Last <b>Corcoran</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Swenny</b> Last <b>Swenny</b>   |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>Yes</b> (or, unknown)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-30-8851</b>   |  |   | 17. INFORMANT<br><b>Joan M. Corcoran (wife)</b>   |  |  |   |   |  |   | Address |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1621</b> IMMEDIATE CAUSE (a) <b>CA OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>HEMOPTYSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>163x</b>   |  |  |  |  |   |   |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/5</b> , 19 <b>68</b> , to <b>8/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |   |   |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. P. Pirnia M.D.</b>  |  |  | DEGREE <b>DR. PIRNIA M.D.</b>  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>8/12/68</b>  |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  | 22e. ADDRESS<br><b>G.B.M.C.</b>  |  |   |   |  |  |   |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>8/16/68</b>  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Pk.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, Maryland</b>                                 |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert P. P. P.</b>   |  |  | ADDRESS<br><b>Singleton Funeral Home/Glen Burnie, Md.</b>  |  |   | 25a. REC'D BY REGISTRAR<br><b>DATE AUG 13 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |   |         |  |  |     |  |  |  |       |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                                   |  |  |
|--|--|--|--|--|--|---|--|-----------------------------------|--|--|
| 11070  |  |  |  |  |  |   |  |                                   |  |  |
| 11078  |  |  |  |  |  |   |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year  |  | 2b. HOUR                          |  |  |
| Eliza Wingate CORNETT  |  |  |  |  |  | 8 21 68   |  | 7:30 P M                          |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS       |  |  |
| Female   |  | white  |  | 6/8/41   |  | 87 YRS.   |  |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |  |
| VA.  |  | USA  |  |  |  | Baltimore Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Garrison, Md.  |  |  | Foxleigh Convalescence Home  |  |  | Housewife   |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |  | Balto  |  | Baltimore  |   | YES  |                                   | 713 Suselage Ave.                            |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |  |  |
| Elijah Wingate   |  |  | Catherine Wingate  |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |  |  |
| No   |  |  | 230-64-6604  |  | French W. Cornett  |   | 713 Suselage Ave.  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 DUE TO, OR AS A CONSEQUENCE OF (b) — (c) —  |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 334x none   |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1967, to Aug. 21, 1968, that (I) (we) lost saw the deceased alive on Aug. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE Irving R Beck MD  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED 8-21-68  |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) IRVING R BECK MD  |  |  |  | 22e. ADDRESS 901 Fueselage Ave Balt. Md. 21220   |  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Removal  |  | Aug. 23, 1968  |  | Pleasant Grove Cem.  |  | Independence Rt #2. VA.   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |
| H. J. Schhardt Owings Mills, Md  |  |  |  | AUG 26 1968  |  | Charles Judge   |  |                                   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--------|--|-----------|---|--------------------------|--|---|----------|---|---------|---------------------------|--------|--|--|--|--|--|--|
| 11071  |  |  |  |  | 11079   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)  |  |  |  |  | First   |  | Middle |  | Last      |   | 2a. DATE OF DEATH        |  |   | 2b. HOUR |   |         |                           |        |  |  |  |  |  |  |
| COURTALIS  |  |  |  |  | Month   |  | Day    |  | Year      |   | 11                       |  |   | A.M.     |   |         |                           |        |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE   |  |        |  |           | 5. DATE OF BIRTH  |                          |  | 6. AGE (In years<br>lost birthday)  |          | IF UNDER 1 YEAR<br>MONTHS                       |         | IF UNDER 24 HRS.<br>HOURS |        |  |  |  |  |  |  |
| Female   |  |  |  |  | White   |  |        |  |           | 8/21/68   |                          |  | 8   |          | 22  |         | 1968                      |        |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |        |  |           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |  | 9. COUNTY OF DEATH  |          |   |         |                           |        |  |  |  |  |  |  |
| Maryland   |  |  |  |  | U.S.A.  |  |        |  |           |   |                          |  | Baltimore,  |          |   |         |                           | Md.    |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |        |  |           | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                          |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |          |   |         |                           |        |  |  |  |  |  |  |
| Towson   |  |  |  |  | St. Joseph Hospital   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before<br>admission) STATE   |  |  |  |  | 13b. COUNTY   |  |        |  |           | 13c. CITY OR TOWN   |                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                          |         |                           |        |  |  |  |  |  |  |
| Maryland   |  |  |  |  |   |  |        |  |           | Baltimore   |                          |  |   |          | 4906 Bowland Ave.                               |         |                           |        |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | First   |  | Middle |  | Last      |   | 15. MOTHER'S MAIDEN NAME |  |   | First    |   | Middle  |                           | Last   |  |  |  |  |  |  |
| Peter  |  |  |  |  |   |  |        |  | Courtalis |   | Eva                      |  |   |          |   |         |                           | Conits |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  |  |  | (If yes give war or dates of service)   |  |        |  |           | 16b. SOCIAL SECURITY NO.  |                          |  | 17. INFORMANT   |          |   | Address |                           |        |  |  |  |  |  |  |
|  |  |  |  |  |   |  |        |  |           |   |                          |  | PETER COURTALIS, 4906 BOWLAND AVE.  |          |   |         |                           |        |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |   |  |        |  |           |   |                          |  |   |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |         |                           |        |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Immaturity</u>  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 777X DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| (c) _____  |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 776X   |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |        |  |           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |          |   |         |                           |        |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |        |  |           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |        |  |           | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 8/21/1968, to 8/22/1968, that (we) last<br>saw the deceased alive on 8/22/1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | 22c. DATE SIGNED  |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| Jose S. Aguto  |  |  |  |  | 8/22/68   |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  |  |  | 22e. ADDRESS  |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| Jose Aguto, M.D.   |  |  |  |  | 7620 York Rd., Towson, Md. 21204  |  |        |  |           |   |                          |  |   |          |   |         |                           |        |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  |  |  | 23b. DATE   |  |        |  |           | 23c. NAME OF CEMETERY OR CREMATORY  |                          |  |   |          | 23d. LOCATION (City or Town) (County) (State)   |         |                           |        |  |  |  |  |  |  |
| BURIAL   |  |  |  |  | 8-23-68   |  |        |  |           | GREEK ORTHODOX  |                          |  |   |          | BALTO, MARYLAND                                 |         |                           |        |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS   |  |        |  |           | 25a. REC'D BY REGISTRAR   |                          |  |   |          | 25b. REGISTRAR'S SIGNATURE                      |         |                           |        |  |  |  |  |  |  |
| Nicholas T. MATTHEWS, 3021 EASTERN AVE.  |  |  |  |  |   |  |        |  |           | DATE AUG 26 1968  |                          |  |   |          | Charles Judge                                   |         |                           |        |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|------------------------|--|-----------------------|--|--|--|-------------------------|--|--|--|
| 11072   |  |  |  |   |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |                        |  |                        |  |                       |  |  |  | 11080                   |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>HELEN ELIZABETH COX</b>   |  |  |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month <b>8</b> Day <b>21</b> Year <b>68</b>                                |  |  |  |                        |  |                        |  |                       |  |  |  | 2b. HOUR <b>7:30</b> AM |  |  |  |
| 3. SEX <b>F.</b>  |  |  |  | 4. RACE <b>white</b>  |  |  |  | 5. DATE OF BIRTH <b>Sept. 20, 1903</b>   |  |  |  | 6. AGE (In years last birthday) <b>64</b> YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS |  | IF UNDER 24 HRS. HOURS |  | IF UNDER 24 HRS. MIN. |  |  |  |                         |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREATER BALTO., MED. CEN.</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bookbinder-Delaney VerneyCo</b>                               |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Baltimore, Md</b>  |  |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  |  | 13c. CITY OR TOWN <b>Balto</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>3834 Elmora Ave.</b> |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>Vavrinec</b> Last <b>Varina</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>unknown</b> Middle <b>Anna</b> Last <b>Cepek</b>                            |  |  |  |  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes, na, or unknown</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>216-03-8368A</b>  |  |  |  | 17. INFORMANT Address <b>Wilbert J. Cox, husband, above</b>  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>METASTASIS OF CARCINOMA OF BREAST</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>170X</b>   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  |  |  | 21f. LOCATION Street or R.F.D. No. <b>8/15</b> City or Town <b>68</b> County <b>8/21</b> State <b>68</b>   |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> , 19 <b>68</b> , to <b>8/21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 22b. SIGNATURE <b>Dr. H. Meshkinpour</b>  |  |  |  | DEGREE <b>MD.</b>   |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  |  | 22c. DATE SIGNED <b>8/21/68</b>  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>H. MESHKINPOUR</b>  |  |  |  | M.D.  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  |  | 23b. DATE <b>8/24/68</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>  |  |  |  | 23d. LOCATION (City or Town) <b>Woodlawn, Md.</b> (County) (State)                           |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |
| 24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>  |  |  |  | ADDRESS <b>3331 Brehms Lane</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>AUG 23 1968</b> DATE  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |                        |  |                        |  |                       |  |  |  |                         |  |  |  |

08011

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11073

11081

|   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>KENNETH</b>  |  |  | First Middle Last<br><b>NMN CROMWELL</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>28</b> Year <b>1968</b>  |  |  | 2b. HOUR<br><b>5:00aM</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Caucasian</b>   |  |  | 5. DATE OF BIRTH<br><b>MAR. 30, 1897</b>  |  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Center</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Jeweler - rep.</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>self employed</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |
| 13e. STREET AND NUMBER<br><b>6109 York Rd.</b>  |  |  | 14. FATHER'S NAME<br>First <b>E. Finley</b> Middle <b>Cromwell</b> Last <b></b>                                   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Georgia</b> Middle <b>McDade</b> Last <b></b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give war and date of service) <b>WW I</b> |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-01-1592A</b>   |  |  | 17. INFORMANT<br><b>Family Records</b>  |  |  | Address   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bacterial endocarditis, mitral valve</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Organism unknown at present</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rheumatic heart disease with mitral stenosis</b> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>410X</b>  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/23, 1968</b> , to <b>8/28, 1968</b> , that (I) (we) last saw the deceased alive on <b>8/28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Charles C. Brown, M.D.</b>   |  |  |   |  |  | DEGREE<br><b>DEGREE</b>   |  |  | 22c. DATE SIGNED<br><b>8/28/68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles C. Brown, M. D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>Aug. 30, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l. Cem.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Brown's Sons, Towson, Md.</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 3 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |

1801-

1801-1802

1801-1802



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |  |                               |  |   |                |  |   |   |  |
|--|--|------------------|--|-------------------------------|--|---|----------------|--|---|---|--|
| <p>11076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>   |  |                  |  |                               |  |   |                |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>ERNEST  |                               | Middle<br>A.   |   | Last<br>CROUSE |  | 2a. DATE KNOWN <input type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> August 1, 1968 |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>1/18/1923 |  | 6. AGE (In years<br>last birthday)<br>45 YRS.   |                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD<br>Month August 1, Year 1968 |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>W. Virginia  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |                |  | 9. COUNTY OF DEATH<br>Howard Baltimore Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Spring Grove State Hospital |                               |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Stone Mason   |                |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before<br>admission) STATE<br>Belair, Maryland   |  |                  | 13b. COUNTY<br>Prince George   |                               |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>John R Crouse  |  |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Maggie Helmondollar   |                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no   |                |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |   |  |
| 17. INFORMANT<br>Alfred Crouse   |  |                  | 1401 Mathews Drive<br>Rockville, Maryland  |                               |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Meningitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Craniocerebral injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>9369  |  |                  |  |                               |  |   |                |  |   |   |  |
| 19a. DATE OF OPERATION<br>7-12-68  |  |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?<br>Subdural hematoma and cerebral contusions              |                               |  |   |                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                  | 21b. TIME OF INJURY Month, Day, Year<br>Unk? 19  |                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Unk?   |                |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE<br>AT WORK  |  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Unk?                        |                               |  | 21f. LOCATION Street or R.F.D. No.<br>Unk?  |                |  | City or Town County State   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |                  |  |                               |  |   |                |  |   |   |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)   |  |                  | Ronald N. Kornblum, M.D.   |                               |  |   |                |  | 22b. DATE SIGNED<br>August 2, 1968  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  | 23b. DATE<br>8/6/68  |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Grandview Memorial Gardens |   |                | 23d. LOCATION (City or Town (County) (State)<br>Bluefield Virginia |   |   |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler Funeral Home   |  |                  | 1351 Rockville Pike<br>Rockville, Md.  |                               |  | 25. REC'D BY REGISTRAR<br>DATE AUG 8 1968   |                |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...   |   |  |

11082  
UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
JANUARY 1, 1964  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
[Illegible text follows]

[Illegible text follows]

11082  
UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
JANUARY 1, 1964  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
[Illegible text follows]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 11073  |  |  |  |   | 11083  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR                                 |  |
| First Middle Last<br>EMILIO MARCELLO CRUZ  |  |  |  |   | Month Day Year<br>AUGUST 25 1968   |  |  | 7:35 AM                                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| Male   |  | Colored  |  | 12/24/20  |  | 47 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Puerto Rico  |  | U.S.A.   |  |   |  | BALTIMORE, Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| FORT HOWARD  |  | VETERANS ADMINISTRATION HOSPITAL   |  | JANITOR   |  | DPT  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                   |  |
| MARYLAND   |  |  |  | BALTIMORE   |  |  |  | 2112 E. BIDDLE STREET                    |  |
| 14. FATHER'S NAME First Middle Last<br>MARCELLO CRUZ   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>CLEMENTINE HERMAIZ                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |  |  |  |
| Yes  |  | WW II  |  | 218 18 0053 Clin. Records, VAH, Fort Howard, Maryland   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>CARDIAC ARRYTHMIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>CONGESTIVE HEART FAILURE<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HOURS<br>HOURS<br>HOURS |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15, 1968, to 8/25/1968, that (I) (we) last saw the deceased alive on 8/25/68 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Robert L. Doyle, M.D.  |  |  |  | 22c. DATE SIGNED<br>8/25/68   |  | 22d. ADDRESS<br>VA HOSPITAL, FORT HOWARD, MARYLAND   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>8/28/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>Chatman Funeral Home   |  |  |  | 25a. REC'D BY REGISTRAR<br>AUG 27 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>John A. Judge  |  |  |  |

11883

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY, N. Y.

DEPARTMENT OF TAXATION

IN SENATE  
JANUARY 10, 1912

REPORT  
OF THE  
COMMISSIONER OF TAXATION  
FOR THE YEAR  
1911

ALBANY, N. Y.:  
JANUARY 10, 1912.

PRINTED BY THE  
STATE OF NEW YORK  
AT ALBANY.

1

RECEIVED  
JAN 10 1912  
STATE OF NEW YORK  
DEPARTMENT OF TAXATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12  
2

2

SEP 1

VR A15 (4)  
30M REV. 1/68

11076

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film 1501 8713788 MC

CERTIFICATE OF DEATH

11084

|  |  |   |   |   |  |   |   |  |  |  |  |
|--|--|---|---|---|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Baby Boy Danker</b>   |  |   | 2a. DATE OF DEATH<br>8 Month 23 Day 68 Year   |   |  | 2b. HOUR<br>3:10 M  |   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>                       |   | 5. DATE OF BIRTH<br><b>8-23-68</b>  |  | 6. AGE (In years last birthday)<br>YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson 21204</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Harford</b>   |   | 13c. CITY OR TOWN<br><b>Joppatowne</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>104 Funsten Court</b> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Roger Danker</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Penelope L. Orchtt</b>                           |   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                 |   | 17. INFORMANT<br>Address               |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis</b><br><b>7769</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                               |  |   |   |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>7620</b>  |  |   |   |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>August 23, 19 68</b> , to <b>August 23, 19 68</b> , that <del>he</del> (we) last saw the deceased alive on <b>August 23, 19 68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>he</del> (we) (did) (did not) view the body after death. |  |   |   |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Jose Aguto</b>  |  |   | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>August 23, 1968</b>                           |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Jose Aguto, M.D.</b>  |  |   | 22e. ADDRESS<br><b>7620 York Rd. Baltimore, Md.</b>   |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  |   | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>   |   |  | 23d. LOCATION (City or Town) (County) (State)      |  |  |
| 24. FUNERAL DIRECTOR   |  |   | ADDRESS   |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |  |

AB001

0.0

DATE: 10/10/1963 TIME: 10:00 AM

TO: Mr. J. Edgar Hoover, Director, FBI

FROM: Mr. [Name], [Title]

SUBJECT: [Subject]

RE: [Reference]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

6. [Text]

7. [Text]

8. [Text]

9. [Text]

10. [Text]

11. [Text]

12. [Text]

13. [Text]

14. [Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-15-64  
30M REV. 11-68

|   |  |   |  |   |   |   |   |  |  |  |  |
|---|--|---|--|---|---|---|---|--|--|--|--|
| Item 18 Film 405 9-26-68am MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |   |   |  |  | 11085  |  |
| 11077<br><b>CERTIFICATE OF DEATH</b>  |  |   |  |   |   |   |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Carolyn C. Dashiell</b>  |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br><b>August 31, 1968</b>                            |   |   |  |  | 2b. HOUR<br><b>9:15a.</b>                                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>                       |  |   | 5. DATE OF BIRTH<br><b>August 21, 1947</b>  |   |   | 6. AGE (In years last birthday)<br><b>20 21 YRS.</b>                 |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore, 21204</b> Md.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CLAIM DEPT.</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Glyndon</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br><b>Rt. 1, Box 45, Worthington Av</b> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>DR. Jarvis D. Case</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Florence H. Haynes</b>               |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-50-2044</b>   |   | 17. INFORMANT Address<br><b>Mr. Chas. R. Dashiell Jr., Rt. 1 Box 45, GLYNDON, MD.</b> |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Tuberculous Necrotizing meningoencephalitis</b><br><b>013.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Mycobacterium tuberculosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>010 X</b>   |  |   |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                               |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>8-13</b> , 19 <b>68</b> , to <b>8-31</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>8-31</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Lillian</b>  |  |   |  |   | DEGREE<br><b>MD.</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-31-68</b>                             |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lillian Gilliani, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>                              |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>9-3-68</b>                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial Gardens</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Md.</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 4 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |  |

11089

UNITED STATES

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

SEP 10 1964

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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

SEP 10 1964

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WASHINGTON, D. C.

SEP 10 1964

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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

SEP 10 1964

11089



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11086

|  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
|--|---------|--|--|--|-----------------------------------|---|--|--|-----------------------------------|----------------------------|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |  |                                   | 2a. DATE KNOWN OF DEATH   |  |  |                                   | 2b. HOUR                   |  |          |
| ALBERT W. DAVIS  |         |  |  |  |                                   | Month 8 Day 19 Year 1968  |  |  |                                   | 6:PM                       |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years lost birthday)  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD   |                                   |                            |  | 2d. HOUR |
| M  | W       | 8/10/11  | 57 YRS.  | MONTHS DAYS  |                                   | HOURS MIN.  |  | Month 8 Day 19 Year 1968   |                                   |                            |  | 6:PM     |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH  |  |  |                                   |                            |  |          |
| MD.  |         | USA  |  |  |                                   | BALTO.  |  |  |                                   |                            |  |          |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                            |  |          |
| ESSEX  |         |  | 611 EASTERN AVE  |  |                                   | PHOTOGRAPHER  |  |  |                                   |                            |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                 |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |                            |  |          |
| MD   |         |  | BALTO  |  | ESSEX                             |   |  |  | 611 EASTERN AVE                   |                            |  |          |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME   |  |                                   |   |  |  |                                   |                            |  |          |
| First Middle Last  |         |  | First Middle Last  |  |                                   |   |  |  |                                   |                            |  |          |
| WILLIAM DAVIS  |         |  | MARGARET WING ROVE   |  |                                   |   |  |  |                                   |                            |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS             |   |  |  |                                   |                            |  |          |
| UNK  |         |  | 215-03-6518  |  | CLARA DAVIS ABOVE                 |   |  |  |                                   |                            |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |                                   |   |  |  |                                   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 1. DEATH WAS CAUSED BY:   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| DUE TO, OR AS A CONSEQUENCE OF <u>HCUV</u>   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| (b) _____  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| DUE TO, OR AS A CONSEQUENCE OF _____   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| (c) _____  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| 4201   |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                            |  |          |
|  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY Month, Day, Year   |  |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                                   |                            |  |          |
|  |         |  | HOUR A.M. P.M. 19  |  |                                   |   |  |  |                                   |                            |  |          |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No |   |  | City or Town   |                                   | County State               |  |          |
|  |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |                                   |   |  |  |                                   |                            |  |          |
| ACTUAL SIGNATURE   |         |  | EXAMINER'S NAME (Type)   |  |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED                  |                            |  |          |
| J. G. Connelly   |         |  | J. G. CONNELLY   |  |                                   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |  |  | 8/21/68                           |                            |  |          |
|  |         |  |  |  |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |  |  |                                   |                            |  |          |
|  |         |  |  |  |                                   | ADDRESS (Street, city, town, or county)   |  |  |                                   |                            |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |                            |  |          |
| BURIAL   |         | 8/22/68  |  | GARDEN OF FAITH  |                                   |   | BALTO. MD.   |  |                                   |                            |  |          |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS  |                                   |   |  | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE |  |          |
| J. G. CONNELLY SONS  |         |  |  | 300 MACE   |                                   |   |  | DATE AUG 26 1968   |                                   | J. Charles Judge           |  |          |

11086

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535



NOV 19 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate and placed in the funeral director's file. The permit should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |   |  |  |   |  |
|---|--|--|--|--|---|--|--|---|--|
| 11079   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |  |  |   | 11087  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last James Oscar Davis  |  |  |  |  |   | 2a. DATE OF DEATH Month Day Year Aug. 10, 1968   |  | 2b. HOUR 2:15 P M                                       |  |
| 3. SEX Male   |  | 4. RACE White  |  | 5. DATE OF BIRTH April 1, 1887   |   | 6. AGE (In years lost birthday) 81 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH Baltimore, Co., Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Grain buyer  |   | 12b. KIND OF BUSINESS OR INDUSTRY Doughnut Corp. of America                                  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  | 13b. COUNTY Baltimore  |  | 13c. CITY OR TOWN Catonsville  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER 2218 Westchester Avenue          |  |
| 14. FATHER'S NAME First Middle Last Robert S. Davis   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Frances Keys  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.  |  | 16b. SOCIAL SECURITY NO. 216-01-1578 A   |  | 17. INFORMANT Baltimore, Md. Mr. Walter Davis  |   | Address 21227 1117 Gloria Avenue   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 Arteriosclerotic Cardio Vasc. Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221 Chronic cerebral thrombosis 1965  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-16-, 1962, to 8-10, 1968, that (I) (we) last saw the deceased alive on 8-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE Harry L. Knipp, M.D.   |  |  |  | 22c. DATE SIGNED 8-12-68   |   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) Harry L. Knipp M. D.   |  |  |  | 22e. ADDRESS 4116 Edmondson Ave. Baltimore, Md. 21229  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 23b. DATE 8/13/1968  |  | 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery  |   | 23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.                             |  |   |  |
| 24. FUNERAL DIRECTOR Easton Funeral Home  |  |  |  | ADDRESS Catonsville, Md.   |   | 25a. REC'D BY REGISTRAR AUG 15 1968  |  | 25b. REC'D BY FUNERAL DIRECTOR                          |  |

JANUARY 1, 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |        |   |                          |  |  |
|---|--|--|--------|---|--------------------------|--|--|
| 11080   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |   |                          | 11088  |  |
| 1. DECEASED NAME<br>(Type or print)   |  | First  | Middle | Last  | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |
| John  |  | A  |        | Dellape Sr.   | Month 8 Day 20 Year 1968 |  | 9:45 A.M.                                    |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH  |                          | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR MONTHS DAYS                  |
| Male  |  | White  |        | September 25, 1893  |                          | 74 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH   |  |
| Italy   |  | U.S.A.   |        |   |                          | Baltimore, Md.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson  |  | St. JOSEPH HOSPITAL  |        | Retired Construction Worker   |                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland  |  |  |        | Baltimore   |                          | 13e. STREET AND NUMBER   |  |
|   |  |  |        |   |                          | 4500 Harcourt Rd., 21214   |  |
| 14. FATHER'S NAME   |  | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |
| Michael   |  |  |        | Dellape   | Rosa                     |  | Russe  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |                          | Address  |  |
| No  |  | 213-01-2659  |        | Mrs Mary Dellape  |                          | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal carcinoma of lungs</u><br><u>1621</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |        |   |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>163X</u>   |  |  |        |   |                          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                          |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                          |  |  |
|   |  |  |        |   |                          |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8/18/</u> , 19 <u>68</u> , to <u>8/20/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8/20/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |   |                          |  |  |
| 22b. SIGNATURE<br><u>Luis E. Renjel</u>   |  | DEGREE   |        | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |                          | 22c. DATE SIGNED<br>8/20/68  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | Luis E. Renjel, M.D.   |        | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |  | 8/24/68  |        | Holy Redeemer   |                          | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR  |  |  |        | ADDRESS   |                          | 25a. REC'D BY REGISTRAR<br>DATE  |  |
| Leonard J Ruck Inc.   |  |  |        | Baltimore, Maryland   |                          | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |





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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |  |  |  |                             |  |
|---|--|---|--|--|--|--|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |                             |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |                             |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First  | Middle   | Last   | 2a. DATE OF DEATH  |  |                             | 2b. HOUR   |
| Julia C. Diener   |  |   |  |  |  | 8 Month / 25 / 68  |  |                             | 2 P.M.   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR             |  |
| f   |  | W   |  | 6/8/86   |  | 82 YRS.  |  | MONTHS DAYS HOURS MIN       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                             |  |
| Maryland  |  | U.S.A.  |  |  |  | Baltimore, (28) Md   |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY                      |
| Catonsville   |  |   | Summit R.H.M.  |  |  | House work   |  |                             | Own Home   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER      |  |
| Maryland  |  |   | Baltimore  |  | Baltimore  |  |  | 1335 Birch Ave.             |  |
| 14. FATHER'S NAME   |  |   | First  | Middle   | Last   | 15. MOTHER'S MAIDEN NAME   |  |                             | First Middle Last                                      |
| John  |  |   |  |  | Diener   | Juliane  |  |                             | Kraemer  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |   | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address  |  |                             |  |
| No  |  |   | 212-32-2970  |  |  | Christina Diener 467 Kensington Rd.  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u><br>1538 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1538  |  |   |  |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |  |
|   |  |   |  |  |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                             |  |
|   |  |   |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town                | County State   |
|   |  |   |  |  |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1966, to Aug 25, 1968, that (I) (we) last saw the deceased alive on 8/22/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |                             |  |
| 22b. SIGNATURE<br>James Nolan   |  |   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>8/25/68 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>J J NOLAN   |  |   |  |  | 22e. ADDRESS<br>Baltimore Md 21229   |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)                    | (State)  |
| Burial  |  | 8/28/68   |  | Lorraine Cemetery  |  | Woodlawn   |  | Maryland                    |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |   |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                             |  |
| Ambrose Inc. 1328 Sulphur Sp Rd   |  |   |  |  | AUG 28 1968  |  | Charles Judge  |                             |  |

11084

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Norwood</b>  |  |   | First <b>E.</b> Middle <b>Dietrich</b> Last                                |   |  | 2a. DATE OF DEATH<br><b>August</b> Month <b>24</b> , Day <b>1968</b> .                          |  | 2b. HOUR<br><b>7:15 P</b>                                |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Nov. 12, 1916</b>  |  | 6. AGE (In years lost birthday)<br><b>51</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>DOA--St. Joseph's Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Restaurant</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1617 Taylor Avenue 1746</b> |  |
| 14. FATHER'S NAME<br>First <b>Harry</b> Middle <b>Dietrich</b> Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Estelle</b> Middle <b>Barlow</b> Last |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>  |  | 17. INFORMANT<br><b>Mrs. Doris L. Dietrich,</b>   |  | Address<br><b>(Same)</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 28, 1967</b> , to <b>Aug 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Larry G. Tilley</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>8-26-68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Larry G Tilley M.D.</b>  |  | 22e. ADDRESS<br><b>1713 Taylor Ave Baltimore, Maryland</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/29/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 27 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

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EXHIBIT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11083

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11091

|   |  |   |   |   |                         |  |   |   |                                      |   |        |
|---|--|---|---|---|-------------------------|--|---|---|--------------------------------------|---|--------|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First   | Middle  | Lost                    | 2a. DATE OF DEATH<br>Month Day Year  |   |   | 2b. HOUR                             |   |        |
| MARTHA  |  |   | GERTRUDE  | DIXON   | 08 03 68                |  |   | 8:30a   |                                      |   |        |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |                         | 6. AGE (In years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                      | IF UNDER 24 HRS.<br>HOURS MIN.                  |        |
| Female  |  | Cauc  |   | 05 15 06  |                         | 62 YRS.  |   |   |                                      |   |        |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. COUNTY OF DEATH   |   |   |                                      |   |        |
| Calvert Co., Md.  |  | U.S.A.  |   |   |                         | Baltimore Co., Md.   |   |   |                                      |   |        |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                         | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |        |
| towsen  |  |   | Greater Balto. Medical Center   |   |                         | Housewife  |   |   | Home                                 |   |        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER               |   |        |
| Md.   |  |   | Calvert   |   | Olivet                  |  |   |   |                                      |   |        |
| 14. FATHER'S NAME   |  |   | First   | Middle  | Lost                    | 15. MOTHER'S MAIDEN NAME   |   |   | First                                | Middle  | Lost   |
| James Edward  |  |   | Joy   |   |                         | Almira   |   |   |                                      |   | Coster |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, name of unknown (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address   |  |   |   |                                      |   |        |
| No  |  |   | 217-30-0393   |   | Dale Dixon, Olivet, Md. |  |   |   |                                      |   |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |                         |  |   |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |        |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>   |  |   |   |   |                         |  |   |   |                                      |   |        |
| 4339 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebrovascular accident &amp; Cerebral</u>   |  |   |   |   |                         |  |   |   |                                      | 12 days   |        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Anoxia</u>   |  |   |   |   |                         |  |   |   |                                      |   |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |                         |  |   |   |                                      |   |        |
| 331 X   |  |   |   |   |                         |  |   |   |                                      |   |        |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/>                                   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                      |   |        |
|   |  |   |   |   |                         |  |   |   |                                      |   |        |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                         |  |   |   |                                      |   |        |
|   |  |   |   |   |                         |  |   |   |                                      |   |        |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |                         | City or Town   |   | County  |                                      | State   |        |
|   |  |   |   |   |                         |  |   |   |                                      |   |        |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> , 19 <u>68</u> , to <u>Aug 3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                         |  |   |   |                                      |   |        |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |   |   |                         | 22d. PHYSICIAN'S NAME (Type)   |   |   |                                      |   |        |
| H. Rhoden   |  | 8-3-68  |   |   |                         | Harold M. Rhoden M.D.  |   |   |                                      |   |        |
|   |  |   |   |   |                         | 22e. ADDRESS   |   |   |                                      |   |        |
|   |  |   |   |   |                         | Great. Balto. Medical Center   |   |   |                                      |   |        |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                         | 23d. LOCATION (City or Town)   |   | (County)  |                                      | (State)   |        |
| Burial  |  | Aug. 6, 1968  |   | Olivet Cemetery   |                         | Olivet   |   | Calvert Co.,  |                                      | Md.   |        |
| 24. FUNERAL DIRECTOR  |  | 24a. REC'D BY REGISTRAR   |   | 24b. REGISTRAR'S SIGNATURE  |                         | 24c. DATE  |   |   |                                      |   |        |
| A. G. Harkness & Son  |  | AUG 7 1968  |   | J. Charles Judge  |                         |  |   |   |                                      |   |        |

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TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
DATE: 11/10/60

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |                  |  |  |                                  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|------------------|--|--|----------------------------------|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|-----|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 11084  |  |  |                  |  |  |                                  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  | 11092  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |                  |  |  |                                  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>SHERMAN</b> First <b>W</b> Middle <b>DORMAN</b> Last  |  |  |                  |  |  |                                  |  |  |  | 2a. DATE KNOWN OF ESTI-<br>MATED <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>12</b> Year <b>1968</b>  |  |  |  |  |  |  |  |   |  | 2b. HOUR <b>M</b>  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>M</b>  |  |  | 4. RACE <b>W</b> |  |  | 5. DATE OF BIRTH <b>10-27-88</b> |  |  | 6. AGE (In years lost birthday) <b>79</b> YRS. |   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Aug</b> Day <b>12</b> Year <b>1968</b> |  |  |  |  |  |  |     |  |  | 2d. HOUR <b>4:20</b> PM |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>  |  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |                                  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <b>Baltimore</b>            |  |  |   |  |  |  |  |  |  | Md. |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |  |  |                  |  |  |                                  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph</b>  |  |  |  |  |  |  |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sales</b>                       |  |  |  |  |     |  |  |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>                                       |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (If deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  |                  |  |  |                                  |  |  |  | 13b. COUNTY <b>Balto.</b>   |  |  |  |  |  |  |  |   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |  |  |     |  |  |                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER <b>1700 Meridene Drive</b> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>Frank</b> Middle <b>D.</b> Last <b>Dorman</b>   |  |  |                  |  |  |                                  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Belle</b> Middle <b>Waterson</b> Last <b></b>   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |                  |  |  |                                  |  |  |  | 16b. SOCIAL SECURITY NO. <b>- - - - -</b>   |  |  |  |  |  |  |  |   |  | 17. INFORMANT <b>L. Gerald Ettlemeyer, Tarrytown, New York</b>   |  |  |  |  |     |  |  |                         |  | ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>887X</b><br>(b) <b>FRACTURE, RIGHT HIP</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |                  |  |  |                                  |  |  |  |   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 DAYS</b>  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>9020</b>  |  |  |                  |  |  |                                  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>8-6-68</b>   |  |  |                  |  |  |                                  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>FRACTURE, RIGHT HIP</b>  |  |  |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |  |  |                  |  |  |                                  |  |  |  | 21b. TIME OF INJURY Month, Day, Year <b>5</b> HOUR <b>A.M.</b> <b>7/30</b> P.M. <b>1968</b>   |  |  |  |  |  |  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <b>FELL IN BATHROOM</b>                    |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |                  |  |  |                                  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>  |  |  |  |  |  |  |  |   |  | 21f. LOCATION Street or R.F.D. No. <b>1700 MERIDENE DR.</b> City or Town <b>BALTIMORE</b> County <b></b> State <b>M.D.</b> |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |                  |  |  |                                  |  |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>                                 |  |  |  |  |  |  |  |   |  | and in my opinion  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>   |  |  |                  |  |  |                                  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  | 22b. DATE SIGNED <b>8-12-68</b>  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>   |  |  |                  |  |  |                                  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |  |                  |  |  |                                  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |  |                  |  |  |                                  |  |  |  | ADDRESS (Street, city, town, or county) <b>Tarrytown, New York</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |  |                  |  |  |                                  |  |  |  | 23b. DATE <b>Aug. 15, 1968</b>  |  |  |  |  |  |  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sleepy Hollow Cem.</b>   |  |  |  |  |     |  |  |                         |  | 23d. LOCATION (City or Town) <b>Tarrytown, New York</b> (County) <b></b> (State) <b></b> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, 1217 St. Paul Street Baltimore, Maryland 21202</b>  |  |  |                  |  |  |                                  |  |  |  | 25a. REC'D BY REGISTRAR <b>AUG 15 1968</b>  |  |  |  |  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |  |     |  |  |                         |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |   |  |  |  |
|---|--|--|--|---|---|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>A</b> <b>CLYDE DORSEY</b>  |  |  |  |   |   | 2a. DATE OF DEATH<br>Month <b>AUG.</b> Day <b>14</b> Year <b>1968</b>                                       |  | 2b. HOUR <b>8 P</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>OCT. 22, 1882</b>  |   | 6. AGE (In years last birthday)<br><b>85</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2110 Rockwell Ave</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Carpenter</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD.</b>  |  |  | 13b. COUNTY <b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Catonsville</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>2110 Rockwell Ave</b>   |  |  |
| 14. FATHER'S NAME First <b>Basil</b> Middle <b>-</b> Last <b>Dorsey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Fannie</b> Middle <b>-</b> Last <b>Day</b>  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>  |   | 17. INFORMANT Address<br><b>Mrs. Sears Hebb Clarksville, Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>   |  |  |  |   |   |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |   |  |  |  |
| (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. 10 YRS.</b>   |  |  |  |   |   |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |   |  |  |  |
| (c)   |  |  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |   |  |   |  |  |  |
| <b>4330</b>   |  |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-24</b> , 19 <b>68</b> , to <b>8-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-2-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Peter Thorpe MD</b>  |  |  |  |   |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-5-68</b>                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Peter Thorpe MD</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>Ellicott City, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8-7-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Morgan Chapel</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodbine Md.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>  |  |  |  |   |   | ADDRESS<br><b>Sykesville, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 12 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

MEDICAL CERTIFICATION

11003

GRAND CENTRAL STATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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11094

|  |  |                              |   |   |  |  |  |  |  |        |      |
|--|--|------------------------------|---|---|--|--|--|--|--|--------|------|
| 1. DECEASED-NAME<br>(Type or print) <u>Sue</u>   |  |                              | First   | Middle  | Lost                                   | 2a. DATE OF DEATH<br>Month <u>8</u> Day <u>24</u> Year <u>1968</u>   |  |  | 2b. HOUR<br><u>1:30 PM</u>   |        |      |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>      |   | 5. DATE OF BIRTH<br><u>Sept 19, 1901</u>  |  |  | 6. AGE (In years<br>lost birthday)<br><u>66</u> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN.                         |        |      |
| 7a. BIRTHPLACE (State or foreign<br>country) <u>BALTO</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><u>BALTO</u> Md.   |  |  |        |      |
| 10. CITY OR TOWN OF DEATH<br><u>Catonville</u>   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>SUMMIT Nsg Home</u> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><u>CLERK</u>                                   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <u>md</u>   |  |                              | 13b. COUNTY<br><u>Balto</u>   |   | 13c. CITY OR TOWN<br><u>Catonville</u> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>48 DUN GARRIE A</u>   |        |      |
| 14. FATHER'S NAME<br><u>Lawrence A</u>   |  |                              | First   | Middle  | Lost                                   | 15. MOTHER'S MAIDEN NAME<br><u>Frances Hessler</u>   |  |  | First  | Middle | Lost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>no</u> (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.<br><u>212-05-2486A</u>   |   |  | 17. INFORMANT<br><u>Lily Dorsey - 48 DUN GARRIE</u> Address  |  |  |  |        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u><br><u>4120</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASHES</u> |  |                              |   |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 mo</u><br><u>years</u><br><u>years</u> |        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><u>443X</u>   |  |                              |   |   |  |  |  |  |  |        |      |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                        |        |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |        |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>August</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>8-23</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |   |   |  |  |  |  |  |        |      |
| 22b. SIGNATURE<br><u>William J. Hoffer</u>   |  |                              |   |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>8-24-68</u>   |        |      |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |                              |   |   |  | 22e. ADDRESS<br><u>98 Smithwood Ave. To Summit</u>   |  |  |  |        |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |                              | 23b. DATE<br><u>8/27/68</u>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New CATHEDRAL</u>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Balto md</u>                               |        |      |
| 24. FUNERAL DIRECTOR<br><u>Thomas J. Kenny Inc</u>   |  |                              |   |   |  | ADDRESS<br><u>Balto Md</u>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 27 1968</u>   |        |      |
|  |  |                              |   |   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |        |      |

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CERTIFICATE OF DEATH

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|---|--|---|--|---|--|---|---|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Bessie</i>   |  | First   |  | Middle  |  | Last                                    |   | 2a. DATE OF DEATH<br>Month <i>August</i> Day <i>28</i> Year <i>1968</i>   |  |  | 2b. HOUR<br><i>5:21 P.</i>                       |  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>                       |  | 5. DATE OF BIRTH<br><i>October 3, 1883</i>  |  |   | 6. AGE (In years last birthday)<br><i>84</i> YRS. |   | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i> |  | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i> |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore.</i> |   |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bentley Springs</i>   |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Bentley Springs Rd.</i>  |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>                     |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Un home.</i>                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <i>Md.</i>   |  |   |  | 13b. COUNTY <i>Baltimore</i>  |  |   |   | 13c. CITY OR TOWN<br><i>Bentley Springs</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>Bentley Springs Rd.</i>                 |  |  |  |
| 14. FATHER'S NAME<br><i>Henry</i>   |  | First   |  | Middle  |  | Last                                    |   | 15. MOTHER'S MAIDEN NAME<br><i>Julia</i>  |  | First  |  | Middle   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>  |  | (If yes give war or dates of service)         |  | 16b. SOCIAL SECURITY NO.<br><i>217-48-9726</i>  |  | 17. INFORMANT<br><i>Cecil C. Doster</i> |   | Address<br><i>Bentley Springs Md.</i>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4109 Coronary Occlusion</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coronary Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>5 min</i><br>2 yr  |  |   |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4201</i>   |  |   |  |   |  |   |   |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>22 Feb</i> , 1966, to <i>28 Aug</i> , 1968, that (I) (we) last saw the deceased alive on <i>7 Aug</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |   |  |   |  |   |   |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Paul D. Shaub</i>  |  |   |  | DEGREE <i>MD</i>  |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>29 Aug 68</i>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Paul D. Shaub</i>  |  |   |  | 22e. ADDRESS<br><i>Shrewsbury, Pa 17361</i>   |  |   |   |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |   |  | 23b. DATE<br><i>Aug 31, 1968</i>  |  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Zion Cemetery</i>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Freeland Md.</i> |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>James J. Hartenstein</i>   |  |   |  | ADDRESS<br><i>New Freedom Pa.</i>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>SEP 3 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |   |   |   |                    |  |  |
|---|--|--|--|---|--|---|---|---|--------------------|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |   |   |                    |  |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |   |   |                    |  |  |
| 11088 CERTIFICATE OF DEATH 11096  |  |  |  |   |  |   |   |   |                    |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>REBECCA DRAUN   |  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>AUGUST 9, 1968  |   |   | 2b. HOUR<br>9 P.M. |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>AUGUST 14, 1893   |  | 6. AGE (In years last birthday)<br>74 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                      |                    | IF UNDER 24 HRS.<br>HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>LITHUANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |   |   |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>—  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1007 SCOTTS HILL DRIVE |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |   |   |                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>—  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 13e. STREET AND NUMBER<br>1007 SCOTTS HILL DRIVE #8 |                    |  |  |
| 14. FATHER'S NAME First Middle Last<br>ISAAC FORMAN   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>CE LIA ISAACSON   |  |   |   |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>—  |  | 17. INFORMANT Address<br>MRS. JACQUELINE P. HUBBERMAN, 3308 MILFORD MIL RD  |  |   |   |   |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br><u>4129</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>&gt; 10 YEARS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u> |  |  |  |   |  |   |   |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4221</u>  |  |  |  |   |  |   |   |   |                    |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>— |   |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>—  |  |   |   |   |                    |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)<br>—                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>—   |  |   |   |   |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>62</u> , to <u>9 Aug</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9 Aug</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |   |                    |  |  |
| 22b. SIGNATURE<br><u>Malcolm S. Druskin, MD</u>   |  |  |  | DEGREE<br>—   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10 Aug 68</u>                |                    |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. MALCOLM S. DRUSKIN  |  |  |  | 22e. ADDRESS<br>2217 SOUTH ROAD   |  |   |   |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>8-11-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH-BETH ISRAEL  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND  |   |   |                    |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD   |  |  |  | ADDRESS<br>—  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 13 1968</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                    |  |  |

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Figure 1. The effect of the concentration of the polymer on the gelation time.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give me carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
|---|--|--|--|--|---|---|---------------------------------|---|-----------------------------------|---|------------------|--|
| 11089   |  |  |  |  | 11097   |   |                                 |   |                                   |   |                  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | 2a. DATE OF DEATH   |   |                                 | 2b. HOUR  |                                   |   |                  |  |
| First   |  | Middle   |  | Last   |   | Month   |                                 | Day   |                                   | Year  |                  |  |
| Mary  |  | M.   |  | duBois   |   | Aug.  |                                 | 8   |                                   | 1968  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years last birthday) |   | IF UNDER 1 YEAR                   |   | IF UNDER 24 HRS. |  |
| F   |  | W  |  | 9-3-1896   |   |   | 77 YRS.                         |   | MONTHS                            |   | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                                 |   |                                   |   |                  |  |
| Pennsylvania  |  | U.S.A.   |  |  |   | Baltimore Md.   |                                 |   |                                   |   |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |                  |  |
| Baltimore 21212   |  |  | 6412 Sherwood Road   |  |   | Ret'd. Bendix Radio   |                                 |   | Radi O                            |   |                  |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE   |  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER          |   |                                   |   |                  |  |
| Md.   |  |  | Baltimore  |  | Balto. 21212 <input type="checkbox"/> NO <input type="checkbox"/> |   | 6412 Sherwood Road              |   |                                   |   |                  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |                                 |   |                                   |   |                  |  |
| First Middle Last   |  |  | First Middle Last  |  |   |   |                                 |   |                                   |   |                  |  |
| John Kloman   |  |  | Anna Ford  |  |   |   |                                 |   |                                   |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT Address   |                                 |   |                                   |   |                  |  |
| No  |  |  | 219-10-1641  |  |   | Mrs. Kathryn A. Burkett Same  |                                 |   |                                   |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |                                 |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>   |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>   |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 450.0   |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |   |                  |  |
|   |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                                 |   |                                   |   |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |                                 |   |                                   |   |                  |  |
|   |  | HOUR A.M. Month Day Year   |  |  |   |   |                                 |   |                                   |   |                  |  |
|   |  | P.M. 19  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   | Street or R.F.D. No.  |                                 | City or Town  |                                   | County State                                    |                  |  |
|   |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 23</u> , 19 <u>67</u> , to <u>Aug 8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |                                 |   |                                   |   |                  |  |
| 22b. SIGNATURE <u>Laurence C. Post M.D.</u>   |  |  |  |  |   | DEGREE  |                                 | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED <u>8/9/68</u>                  |                  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Laurence C. Post</u>  |  |  |  |  |   | 22e. ADDRESS <u>6805 York Road</u>  |                                 |   |                                   |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |                                 | (County)  |                                   | (State)   |                  |  |
| Burial  |  | 8-12-68  |  | Moreland Memorial Park   |   | Baltimore   |                                 | County,   |                                   | Md.   |                  |  |
| 24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>  |  |  |  |  |   | ADDRESS <u>4005 York Road Balto., Md. 21212</u>   |                                 | 25a. REC'D BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |                  |  |
|   |  |  |  |  |   | DATE <u>AUG 12 1968</u>   |                                 |   |                                   |   |                  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |   |   |  |   |  |                        |   |      |
|--|--|------------------------------|--|---|---|--|---|--|------------------------|---|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |   |  |   |  |                        |   |      |
| CERTIFICATE OF DEATH   |  |                              |  |   |   |  |   |  |                        |   |      |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  | Middle  | Last  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                        |   |      |
| Edward Joseph Duda   |  |                              |  |   |   | 8/25/68 Month Day Year   |   | 9P. M  |                        |   |      |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                        |   |      |
| Male   |  | White                        |  | Dec. 18, 1911   |   | 56 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN.                                       |                        |   |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   | Md.  |                        |   |      |
| Balto. Md.   |  | U.S.A.                       |  |   |   | Baltimore County   |   |  |                        |   |      |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |   |      |
| Baltimore  |  |                              | 3042 Woodside Ave.   |   |   | Clerk  |   | American Oil Co.   |                        |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |   |      |
| Md.  |  |                              | Balto.   |   | Parkville   |  | YES   |  | 3042 Woodside Avenue   |   |      |
| 14. FATHER'S NAME  |  |                              | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |   |  | First                  | Middle  | Last |
| Hieronimus Duda  |  |                              |  |   |   | Pauline Duda   |   |  |                        |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |   | Address  |                        |   |      |
| No   |  |                              | 212-07-8568  |   | Irene A. Duda   |  |   | 3042 Woodside Ave.   |                        |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonitis, Viral</u><br>480X DUE TO, OR AS A CONSEQUENCE OF <u>Dehydration, debilitation, 1 wk.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |                              |  |   |   |  |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 dys |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>492X <u>Chronic Severe Paralysis agitans, Progressive</u>   |  |                              |  |   |   |  |   |  |                        |   |      |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |   |      |
|  |  |                              |  |   |   |  |   |  |                        |   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                        |   |      |
|  |  |                              |  |   |   |  |   |  |                        |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                        |   |      |
|  |  |                              |  |   |   |  |   |  |                        |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1968, to Aug 1968, and that (I) (we) last saw the deceased alive on Aug 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |                              |  |   |   |  |   |  |                        |   |      |
| 22b. SIGNATURE   |  |                              | F.T. KASIK M.D.  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED 8/27/68   |                        |   |      |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              | F.T. KASIK M.D.  |   |   | 22e. ADDRESS 9005 Harford Rd. Balto.   |   |  |                        |   |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE 8-28-68  |   | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery |  | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland                 |  |                        |   |      |
| 24. FUNERAL DIRECTOR   |  |                              | ADDRESS John C. Miller Inc-6415 Belair Rd.-21206                             |   |   | 25a. REC'D BY REGISTRAR DATE AUG 29 1968   |   | 25b. REGISTRAR'S SIGNATURE Charles Judge                             |                        |   |      |

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*Commensal*  
*habitation*

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*habitation*

*habitation*  
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*habitation*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |   |  |  |                 |
|--|--|--|--|---|---|--|--|---|--|--|-----------------|
| 11091 CERTIFICATE OF DEATH 11099   |  |  |  |   |   |  |  |   |  |  |                 |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>SISTER AGATHA (DUNN)   |  |  |  |   |   | 2a. DATE OF DEATH Month Day Year<br>AUG 16 1968  |  |   | 2b. HOUR<br>M                                  |  |                 |
| 3. SEX<br>F  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MARCH 2, 1893   |   | 6. AGE (In years last birthday)<br>75 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                   |                 |
| 7a. BIRTHPLACE (State or foreign country)<br>MASS.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |  |   |  |  |                 |
| 10. CITY OR TOWN OF DEATH<br>STEVENSON   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VILLA JULIE INF. |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>TEACHER |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RELIGIOUS |  |                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.   |  |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>STEVENSON  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>VALLEY RD.           |  |                 |
| 14. FATHER'S NAME First Middle Last<br>JOHN P. DUNN  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>BRIDGET MORAN   |   |  |  |   |  |  |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>—   |   | 17. INFORMANT Address<br>Sister John Marie - Villa Julie   |  |   |  |  |                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Coronary Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerosis |  |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hr<br>yr<br>yr |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201 None  |  |  |  |   |   |  |  |   |  |  |                 |
| 19a. DATE OF OPERATION<br>None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |  |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |  |  |                 |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |  |  |                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 16 Aug, 1968 to 16 Aug, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |   |  |  |                 |
| 22b. SIGNATURE<br>August Dilling Jr. M.D.  |  |  |  |   |   | DEGREE<br>M.D.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>17 Aug 68                                    |                 |
| 22d. PHYSICIAN'S NAME (Type)<br>August Dilling Jr. M.D.  |  |  |  |   |   | 22e. ADDRESS<br>1002 St. B. 1 St.  |  |   |  |  |                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8-19-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Convent Cem.  |   |  | 23d. LOCATION (City or Town)<br>Daleston   |   | (County)<br>Ind.                               |  | (State)<br>Ind. |
| 24. FUNERAL DIRECTOR<br>Trinity-Convent S.F.H. - Catonsville Md.   |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>AUG 20 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |                 |

MEDICAL CERTIFICATION

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |                 |      |   |      |                            |   |  |  |
|--|---------|------------------------------|--|-----------------|------|---|------|----------------------------|---|--|--|
| 11092 Items 7, 8, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100  |         |                              |  |                 |      |   |      |                            |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |                 |      | 2a. DATE KNOWN OF DEATH   |      |                            | 2b. HOUR                                      |  |  |
| LORETTA  |         |                              | DINNING  |                 |      | Month Day Year  |      |                            | 8 10 19 68                                    |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD   |   |  | 2d. HOUR                                     |
| Female   | White   |                              | 65 YRS   | MONTHS          | DAYS | HOURS   | MIN. | Month Day Year             |   |  | 19 68 5:50                                   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED      |      | NEVER MARRIED   |      | 9. COUNTY OF DEATH         |   |  | MD.  |
| West Virginia  |         | US                           |  | WIDOWED         |      | DIVORCED  |      | Balto.                     |   |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |                            | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |
| Catonsville  |         |                              | Springgrove Hospital   |                 |      |   |      |                            |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. CITY OR TOWN  |                 |      | 13d. INSIDE CITY LIMITS?  |      |                            | 13e. STREET AND NUMBER                        |  |  |
| Md.  |         |                              | Balto.   |                 |      | YES NO  |      |                            | Chesapeake Avenue Springgrove Hospital        |  |  |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |                 |      |   |      |                            |   |  |  |
| First Middle Last  |         |                              | First Middle Last  |                 |      |   |      |                            |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT   |      |                            | ADDRESS                                       |  |  |
|  |         |                              |  |                 |      |   |      |                            |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration of bolus of food</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |         |                              |  |                 |      |   |      |                            |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Schizophrenia</u>   |         |                              |  |                 |      |   |      |                            |   |  |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      | 20. AUTOPSY?  |      |                            | YES NO  |  |  |
|  |         |                              |  |                 |      |   |      |                            |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |                            |   |  |  |
| PRIMARY OR CONTRIBUTING CAUSE OF DEATH   |         |                              | 8 10 1968  |                 |      | Aspirated food  |      |                            |   |  |  |
| 21d. INJURY OCCURRED   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |      |                            |   |  |  |
| WHILE AT WORK NOT WHILE AT WORK  |         |                              | Hospital   |                 |      | Springgrove Hosp. Catonsville Balto. Md.  |      |                            |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection, Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner   |         |                              |  |                 |      |   |      |                            |   |  |  |
| ACTUAL SIGNATURE   |         |                              | CHIEF MEDICAL EXAMINER   |                 |      | 22b. DATE SIGNED  |      |                            |   |  |  |
| EXAMINER'S NAME (Type)   |         |                              | DEPUTY MEDICAL EXAMINER  |                 |      | August 11, 1968   |      |                            |   |  |  |
| Ronald N. Kornblum, M.D.   |         |                              | ADDRESS (Street, city, town, or county)                                      |                 |      |   |      |                            |   |  |  |
| 23a. BURIAL (CREMATION REMOVAL) (Specify)  |         |                              | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY  |      |                            | 23d. LOCATION (City or Town) (County) (State) |  |  |
|  |         |                              | 8, 23 '68  |                 |      | Baltimore, Md.  |      |                            |   |  |  |
| 24. FUNERAL DIRECTOR   |         |                              |  |                 |      | 25a. REC'D BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE |   |  |  |
|  |         |                              |  |                 |      | DATE AUG 26 1968  |      | J. Charles J. J.           |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |   |  |                                |  |
|--|--|--|---|---|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |  |                                |  |
| 11093  |  |  |   |   |   |   |  |                                |  |
| 11101  |  |  |   |   |   |   |  |                                |  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last                             |   |   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                | 2b. HOUR                                     |
| Anna   |  |  | C. Engle                                      |   |   | August 28 1968  |  |                                | 6:30 PM                                      |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| Female   |  | White  |   | 12-19-1888  |   | 79 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                |  |
| Maryland   |  | U.S.A.   |   |   |   | Baltimore Md.   |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |
| Towson   |  | St. Joseph Hospital  |   |   |   |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. CITY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER         |  |
| Maryland   |  | Baltimore  |   | Essex   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 625 Eastern Blvd. - 21221      |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last |   |   |   |  |                                |  |
| GEORGE CLOVELL   |  |  | ANNA SACHS                                    |   |   |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.                      |   | 17. INFORMANT Address   |   |  |                                |  |
| UNK  |  |  | NONE  |   | MRS G.S. LYNN 709 EASTERN   |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized purulent peritonitis.</u><br><u>153.3</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Break up of entero-anastomosis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive heart failure and pulmonary emboli.</u> |  |  |   |   |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>153.3</u>   |  |  |   |   |   |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |
| 8/14/68<br>8/27/68   |  | Carcinoma of sigmoid<br>Ca.-P/O ant. resection                               |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |                                |  |
|  |  |  |   |   |   |   |  |                                |  |
| 22a. I certify that (this hospital) attended the deceased from <u>8/12/</u> , 19 <u>68</u> , to <u>8/28/</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8/28/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |                                |  |
| 22b. SIGNATURE<br><u>Ines Ciliani</u>  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>8/29/68</u>                                   |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Ines Ciliani, M.D.</u>  |  |  |   |   | 22e. ADDRESS<br><u>7620 York Rd., Towson, Md. 21204</u>   |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><u>8/31/68</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OAK LAWN</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTO. MD</u>                               |  |                                |  |
| 24. FUNERAL DIRECTOR<br><u>J.E. CONNELLY SONS</u>  |  | ADDRESS<br><u>300 MACE</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 3 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |                                |  |



Investigation of the activities of the  
Bureau of Investigation of the  
Department of Justice.

Division of Investigation  
Bureau of Investigation  
Department of Justice

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 11094   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |   |  | 11102   |  |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>EDWARD</b>  |  |   | First Middle Last<br><b>FAISON EL</b>                               |   |  | 2a. DATE OF DEATH<br>8 Month 28 Year 88   |  | 2b. HOUR<br>7:45 PM   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br><b>7/30/18</b>  |  | 6. AGE (In years lost birthday)<br><b>50</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b>                                 |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1000 W. 43rd Street</b>            |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>WILLIAM J. FAISON EL</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>ALLIE JAMES</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWW11</b>  |   | 17. INFORMANT<br>Address<br><b>217 12 87 79 CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>4000</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>NEPHROSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MALIGNANT HYPERTENSION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>YEARS</b><br><b>YEARS</b> |  |   |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>445X</b>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>8/13/68</b> , 19____, to <b>8/28/68</b> , 19____, that (X) (we) lost saw the deceased alive on <b>8/28/68</b> , 19____, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Jorge A. Fabara</i>  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/29/68</b>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JORGE A. FABARA, M. D.</b>   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Type)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>9-3-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Charles R. Law</i>   |  | ADDRESS<br><b>CHARLES R. LAW FUNERAL HOME</b>   |   | 25a. RECD BY REGISTRAR<br>DATE<br><b>SEP. 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |  |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                         |  |  |   |   |   |   |   |
|--|-------------------------|--|--|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print) <i>William Harrison Finke</i>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month <i>Aug</i> Day <i>16</i> Year <i>19</i> |   |   | 2b. HOUR <i>5:40</i> M <i>PM</i>  |   |   |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br><i>30 May 1889</i>                                       | 6. AGE (In years just birthday)<br><i>79</i> YRS   | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i>  | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i>                        | 2c. DATE PRONOUNCED DEAD<br>Month <i>Aug</i> Day <i>16</i> Year <i>19</i> <i>68</i>   |   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><i>BALTIMORE</i>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO-RURAL Finke</i>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Retired Civil Ser. Employee</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |                         |  | 13b. COUNTY <i>Baltimore</i>   |   | 13c. CITY OR TOWN.<br><i>Parkview</i>                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               | 13e. STREET AND NUMBER<br><i>8004 Chesnut</i> |   |
| 14. FATHER'S NAME<br>First <i>Frank</i> Middle <i>Anthony</i> Last <i>Finke</i>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Helen</i> Middle <i>Fraunholz</i> Last <i>Fraunholz</i>                           |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>  |                         |  | 16b. SOCIAL SECURITY NO.<br><i>218-40-1440</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Harry F Finke 934 Patterson Park Ave</i> |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i><br><i>185X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>undet.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>177X</i>  |                         |  |  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>19</i> P.M.             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |   | County  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |   |   |   |
| ACTUAL SIGNATURE<br><i>John C. Hyle</i>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   | 22b. DATE SIGNED<br><i>8-16-68</i>  |   |   |
| EXAMINER'S NAME (Type)<br><i>JOHN C. Hyle</i>  |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |
| ADDRESS (Street, city, town, or county) <i>7537 Belair Rd</i>  |                         |  |  |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                         | 23b. DATE<br><i>8/20/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>   |   |   |
| 24. FUNERAL DIRECTOR<br><i>Leonard J Ruck Inc Baltimore, Maryland</i>  |                         |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>AUG 19 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J...</i>             |

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|-----------------------------------|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| Items 5, 6, & 13 of Form 1004 of 10-60 kK  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 11096  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 11104  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last PAULINE A. FLANAGAN   |  |   |  |  |  | 2a. DATE OF DEATH Month 25 Day 68 Year  |  |  |  | 2b. HOUR 1:55 P.M.                |  |  |  |
| 3. SEX F.  |  | 4. RACE W.  |  | 5. DATE OF BIRTH June 6, 1890  |  | 6. AGE (In years last birthday) 78 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.       |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) BALTO. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH BALTO. Md  |  |  |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH CATONSVILLE  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHADY NOOK |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.  |  | 13b. COUNTY BALTO.  |  | 13c. CITY OR TOWN CATONSVILLE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET AND NUMBER 17 Overhill Road 21228                        |  |                                   |  |  |  |
| 14. FATHER'S NAME First Middle Last FRANCIS KING   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last MATILDA SHAFER  |  |   |  |  |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO  |  | 16b. SOCIAL SECURITY NO. 214-54-228   |  | 17. INFORMANT HOWARD J. KREIS  |  |   |  | Address BALTO. Md 21207  |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| IMMEDIATE CAUSE (a) 4129 Anterior wall myocardial infarction 1 yr +  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 4221 Diabetes Mellitus   |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |                                   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)            |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County   |  | State                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 17, 1968, to Aug 25, 1968, that (I) (we) last saw the deceased alive on Aug 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |                                   |  |  |  |
| 22b. SIGNATURE John Nesbitt Jr. M.D. DEGREE  |  | 22c. DATE SIGNED 8-26-68  |  | 22d. PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR  |  | 22e. ADDRESS 1009 Frederick Bl, Baltimore Md 21228  |  |  |  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT Specify BURIAL   |  | 23b. DATE 8/28/68   |  | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer   |  | 23d. LOCATION (City or Town) BALTIMORE  |  | (County)   |  | (State) Md                        |  |  |  |
| 24. FUNERAL DIRECTOR C. S. Mac Nabb  |  | ADDRESS 301 Frederick Ave Baltimore Md  |  | 25a. REC'D BY REGISTRAR DATE AUG 28 1968   |  | 25b. REGISTRAR'S SIGNATURE Charles Jones  |  |  |  |                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| EDITH GUNDELACH FLORENZ  |  |  |  |  |  | AUGUST   |  |  | 2nd., 1968   |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| FEMALE   |  |  | WHITE  |  |  | 10-29-1885   |  |  | 82 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| St. Joseph, Mo.  |  |  | U.S.A.   |  |  |  |  |  | Baltimore County   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Lutherville, Md.   |  |  | College Manor  |  |  | Housewife  |  |  | Own Hpme   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Maryland   |  |  |  |  |  | Baltimore  |  |  | 308 Eastway Court, Balto., Md.   |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |
| CHARLES A GUNDELACH  |  |  | THEODORA LONG  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO   |  |  | 16b. SOCIAL SECURITY NO. 219-12-7050   |  |  | 17. INFORMANT Address  |  |  | Timonium, Maryland   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 1538   |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 1538   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950, 19, to 1968, 19, that (I) (we) last saw the deceased alive on July 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Dr. William G. Helfrich   |  |  | 22c. DATE SIGNED 8-2-68  |  |  | 22d. ADDRESS 5006 Roland Ave., Balto., Md.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE 8-5-68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge   |  |  | 23d. LOCATION (City or Town) (County) (State) Pikesville Balto. Md.                          |  |  |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto., Md.  |  |  | 25a. REC'D BY REGISTRAR AUG 5 1968   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 48 hours after death.

VR A15 (4)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(Type or print) <b>SARAH J. FOSTER</b>  |  | First Middle Last   |  | 2a. DATE OF DEATH<br>August <sup>Month</sup> 21, Day 1968   |  | 2b. HOUR<br>5:00 PM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>12-22-77  |  | 6. AGE (In years last birthday)<br>90 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>England  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1006 Sanbourne Road |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>1006 Sanbourne Road   |  | 13f. CITY OR TOWN<br>21207  |  | 14. FATHER'S NAME<br>George Bowden  |  | 15. MOTHER'S MAIDEN NAME<br>Ann Davis   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Lillian E. Ireland, 1006 Sanbourne Rd.  |  | Address<br>21207  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardio Vascular Disease</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 13, 1968</u> to <u>Aug 21, 1968</u> , that (I) (we) saw the deceased alive on <u>Aug 20, 1968</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Harry L. Knipp, MD</u>   |  | 22c. DATE SIGNED<br>8-21-68   |  | 22d. PHYSICIAN'S NAME (Type)<br>Dr. Harry L. Knipp  |  |   |  |
| 22e. ADDRESS<br>4116 Edmondson Avenue, Balto., Md.  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>8-23-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cemetery                                       |  |
| 23d. LOCATION (City or Town)<br>O'Donnell St., Balto., Md.  |  | 23e. LOCATION (County)<br>(State)   |  | 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  | 25a. REC'D BY REGISTRAR<br>AUG 22 1968  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>James J. Judge</u>   |  | 25c. DATE<br>AUG 22 1968  |  |   |  |   |  |

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24



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |   |  |  |   |  |  |  |   |
|---|--|-------------------------------|---|--|--|---|--|--|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |   |  |  |   |  |  |  |   |
| CERTIFICATE OF DEATH  |  |                               |   |  |  |   |  |  |  |   |
| 11099   |  |                               |   |  |  |   |  |  |  |   |
| 11107   |  |                               |   |  |  |   |  |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u>   |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> |   |  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix + Md. Ave</u>   |  |                               |   |  | c. LENGTH OF STAY IN 1b <u>55 yrs.</u>   |   |  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MARYLAND AVENUE Phoenix Md</u>  |  |                               |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>TRICE</u> Last <u>FOX</u>  |  |                               | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>16</u> Year <u>1968</u>                                    |  |  |   |  |  |  |   |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 3 1868</u>   |  | 9. AGE (In years last birthday) <u>99</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>   |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>King Queen Co. Va.</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |   |
| 13. FATHER'S NAME <u>John F TRICE</u>   |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <u>MARTHA Anna Cook</u>   |   |  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |                               | 16. SOCIAL SECURITY NO. <u>220-48-7084</u>  |  |  | 17. INFORMANT <u>MARY FRANCES LINS</u> Address <u>Phoenix Md</u>              |  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4409 Congestive Heart Failure</u><br>DUE TO (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) <u>1 year</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                               |   |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500</u>   |  |                               |   |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                           |  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 8th</u> , 19 <u>65</u> , to <u>August 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>August 10</u> , 19 <u>68</u> , and that death occurred at <u>11:29</u> M, from the causes and on the date stated above.                                       |  |                               |   |  |  |   |  |  |  |   |
| 22a. SIGNATURE <u>Henry L. McCorkle</u>   |  |                               |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |   | 22b. DATE SIGNED   |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY L. MCCORKLE MD</u>  |  |                               |   |  | 22d. ADDRESS <u>Phoenix, Md. (21131)</u>   |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |                               | 23b. DATE THEREOF <u>8-19-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Jackson Reform</u>   |   | 23d. LOCATION (City, town or county) (State) <u>Jackson MD</u> |  |  |   |
| 24. FUNERAL DIRECTOR <u>Wm. Cook. Brooks Towson</u> ADDRESS <u>1050 York Rd Towson Md</u>   |  |                               |   |  | 25a. REC'D BY REGISTRAR <u>2/20X</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                |  |  |   |
|   |  |                               |   |  | DATE <u>AUG 19 1968</u>  |   |  |  |  |   |

10211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11100

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11108

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Jennie (Giovannina)</b>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>August 2, 1968</b>  |  |  | 2b. HOUR<br><b>8:45 AM</b>  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>August 10, 1883</b>  |  |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.   |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Italy</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b>                             |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Perry Hall</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>143 A-1 Perry Hall Rd.</b>            |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Cosmo Vinci</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>? Monti</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)                                       |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-48-6243</b>  |  |  | 17. INFORMANT<br>Address<br><b>Mrs. Catherine M. Monaco (Same)</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>431.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>337X</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                       |  |  |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Myocardial infarction</b>   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/28/</b> 19 <b>68</b> , to <b>8/2/</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/2/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Lorna Gaudiel</i>  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>8/2/68</b>   |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lorna Gaudiel, M.D.</b>  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition<br><b>Entombment</b>   |  |  | 23b. DATE<br><b>8/5/68.</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Pk. Mausoleum</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 5 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEASED-NAME<br>(Type or print) <i>Stephen Middle Lost</i>   |  | 2a. DATE OF DEATH<br>Month <i>8</i> Day <i>11</i> Year <i>68</i>  |   | 2b. HOUR<br><i>38</i> M   |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br><i>11-24-1890</i>   | 6. AGE (In years lost birthday)<br><i>77</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                         |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Balto.</i> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Chesapeake Manor</i>                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Heat Treater</i>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>B. &amp; D. Mfg. Co.</i>                                |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>  | 13b. COUNTY <i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Towson</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><i>248 Ridge Avenue</i>                 |
| 14. FATHER'S NAME First <i>Carroll</i> Middle <i>Freeland</i> Last   |  | 15. MOTHER'S MAIDEN NAME First <i>Cecelia</i> Middle <i>Ambrose</i> Last  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <i>no</i> (If yes, give war or dates of service) <i>None</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>218-18-2307</i>  | 17. INFORMANT<br><i>Family records</i> Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>450x</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>465x</i><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 minutes</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>Gangrene of foot 1955 &amp; Chronic Pancreatitis &amp; Esophy Sena</i>  |  |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-6</i> , 19 <i>65</i> to <i>8-11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |   |   |
| 22b. SIGNATURE<br><i>Walter T. Kees</i>  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><i>August 1968</i>  |   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><i>WALTER T. KEES</i>  | 22e. ADDRESS<br><i>Cockeysville, Md.</i>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 23b. DATE<br><i>Aug. 14, 1968</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley Memorial</i>  | 23d. LOCATION (City or Town) (County) (State)<br><i>Cockeysville, Maryland</i>                  |   |
| 24. FUNERAL DIRECTOR<br><i>John Burns &amp; Sons</i>   | 25a. REC'D BY REGISTRAR<br><i>John Burns &amp; Sons</i>  | 25b. DATE<br><i>AUG 14 1968</i>   | 25c. REGISTRAR'S SIGNATURE<br><i>John Burns &amp; Sons</i>                                      |   |

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CERTIFICATE OF DEATH

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Marie Friers</b>   |  | First Middle Last  |  | 2a. DATE OF DEATH<br><b>Aug. Month 9 Day 68</b> Year  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>MAR. 14 1890</b>   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rigeway Manor</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Our home - Housewife</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Baltimore</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>CHARLES H. DANNETT</b>  |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME<br><b>CHRISTIANA GILES</b>   |  | First Middle Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-65100</b>  |  | 17. INFORMANT<br><b>Charlotte Feigley SAME AS #13</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 Jan, 1968</b> , to <b>9 Aug, 1968</b> , that (I) (we) last saw the deceased alive on <b>9 Aug, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William Goodman, MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10 Aug 68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Goodman</b>  |  |  |  | 22e. ADDRESS<br><b>1334 Sulphur Spring Road Balto. Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>AUG 13, 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Balto. Md.</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>J.T. Stansbury</b>   |  |  |  | ADDRESS<br><b>6411 Wigdson Mill Rd.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 13 1968</b>  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John H. Judge</b>   |  |

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EXHIBIT OF DEATH

01111

NO. 1 - 1900

NO. 2 - 1900

NO. 3 - 1900

NO. 4 - 1900

NO. 5 - 1900

NO. 6 - 1900

NO. 7 - 1900

NO. 8 - 1900

NO. 9 - 1900

NO. 10 - 1900

NO. 11 - 1900

NO. 12 - 1900

NO. 13 - 1900

NO. 14 - 1900

NO. 15 - 1900

NO. 16 - 1900

NO. 17 - 1900

NO. 18 - 1900

NO. 19 - 1900

NO. 20 - 1900

NO. 21 - 1900

NO. 22 - 1900

NO. 23 - 1900

NO. 24 - 1900

NO. 25 - 1900

NO. 26 - 1900

NO. 27 - 1900

NO. 28 - 1900

NO. 29 - 1900

NO. 30 - 1900

NO. 31 - 1900

NO. 32 - 1900

NO. 33 - 1900

NO. 34 - 1900

NO. 35 - 1900

NO. 36 - 1900

NO. 37 - 1900

NO. 38 - 1900

NO. 39 - 1900

NO. 40 - 1900

NO. 41 - 1900

NO. 42 - 1900

NO. 43 - 1900

NO. 44 - 1900

NO. 45 - 1900

NO. 46 - 1900

# FOR STATE HEALTH DEPT.

11103

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|  |                                |   |  |  |
|--|--------------------------------|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ELFRIEDA PRICE FUNK</b>   |                                | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>AUG. 15, 1968</b> |  | 2b. HOUR <b>M</b>  |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b>           | 5. DATE OF BIRTH <b>June 21, 1882</b>   | 6. AGE (In years last birthday) <b>86</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |
| 7a. BIRTHPLACE (State or foreign country) <b>Germany</b>   |                                | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>  |                                | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                                | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Towson</b>  |
| 14. FATHER'S NAME First <b>William</b> Middle <b>Koehler</b> Last <b>Koehler</b>   |                                | 15. MOTHER'S MAIDEN NAME First <b>Wilhelmina</b> Middle <b>Gaulle</b> Last <b>Gaulle</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>  |
| 16b. SOCIAL SECURITY NO. <b>217-20-9834</b>  |                                | 17. INFORMANT <b>Family Records</b>   |  | ADDRESS  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Fracture of Left Hip</b><br>(b) <b>Fracture of Left Hip</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Fracture of Left Hip</b><br>(c) <b>Fracture of Left Hip</b>   |                                |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>5 weeks</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>9027 Fracture of Left Hip 7/68 Fracture of Right Shoulder</b>  |                                |   |  |  |
| 19a. DATE OF OPERATION <b>7/1/68</b>   |                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |                                | 21b. TIME OF INJURY Month, Day, Year <b>11:00 P.M. 10/30/68</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Excellent of Ball Feller Hospital</b>                                 |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |                                | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Nursing Home Hospital</b>   |  | 21f. LOCATION Street or R.F.D. No <b>1011</b> City or Town <b>Stevenson</b> County <b>Harford</b> State <b>Md.</b>                                       |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                |   |  |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>   |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED <b>8/18/68</b>  |
| EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>   |                                | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | ADDRESS (Street, city, town, or county)  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE <b>Aug. 19, 1968</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>  |                                | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>  |  | 25b. REGISTRAR'S SIGNATURE   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                   |   |  |   |                              |                            |  |
|---|--|--|--|--|-------------------|---|--|---|------------------------------|----------------------------|--|
| 11108 CERTIFICATE OF DEATH 11112  |  |  |  |  |                   |   |  |   |                              |                            |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |                   | 2a. DATE OF DEATH   |  | 2b. HOUR  |                              |                            |  |
| Bertha Evelyn Gallina   |  |  |  |  |                   | 8-23-68   |  | M   |                              |                            |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |                              |                            |  |
| Female  |  | White  |  | June 12, 1906  |                   | 62 YRS.   |  | MONTHS DAYS HOURS MIN.  |                              |                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |   |                              |                            |  |
| Maine   |  | USA  |  |  |                   | Baltimore County  |  | Md.   |                              |                            |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                              |                            |  |
| Balto. County   |  |  | 6205 Frederick Road  |  |                   |   |  |   |                              |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER       |                            |  |
| 6205 Fred. Ave.   |  |  | Baltimore  |  | (Balto.)          |   |  |   | 6205 Frederick Ave.          |                            |  |
| 14. FATHER'S NAME   |  |  | First Middle Last  |  |                   | 15. MOTHER'S MAIDEN NAME  |  |   | First Middle Last            |                            |  |
| Arthur P. Winslow   |  |  |  |  |                   | Mary E. Hinckle   |  |   |                              |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  |                   | 17. INFORMANT   |  |   | Address                      |                            |  |
| No  |  |  | 005-01-9990  |  |                   | Samuel S. Gallina   |  |   | 121 Settle Dr. Eikridge, Md. |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                   |   |  |   |                              |                            |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                   |   |  |   |                              |                            |  |
| IMMEDIATE CAUSE (a) <u>Heart myo cardiac infarction</u>   |  |  |  |  |                   |   |  |   |                              |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                   |   |  |   |                              |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |                   |   |  |   |                              |                            |  |
| (b) <u>arteriosclerotic cardiac-vascular</u>  |  |  |  |  |                   |   |  |   |                              |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                   |   |  |   |                              |                            |  |
| (c) <u>Alcohol</u>  |  |  |  |  |                   |   |  |   |                              |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |                   |   |  |   |                              |                            |  |
| 4201  |  |  |  |  |                   |   |  |   |                              |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                              |                            |  |
|   |  |  |  |  |                   |   |  |   |                              |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |   |  |   |                              |                            |  |
|   |  | HOUR A.M. Month Day Year   |  |  |                   |   |  |   |                              |                            |  |
|   |  | P.M. 19  |  |  |                   |   |  |   |                              |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |                   | Street or R.F.D. No.  |  | City or Town County State   |                              |                            |  |
|   |  |  |  |  |                   |   |  |   |                              |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1/54, 1954, to 8/28, 1968, that (I) (we) last saw the deceased alive on 8/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                   |   |  |   |                              |                            |  |
| 22b. SIGNATURE  |  |  |  |  |                   | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                              | 22c. DATE SIGNED           |  |
| Dr. John Shaw   |  |  |  |  |                   |   |  |   |                              | 8/28/68                    |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |                   | 22e. ADDRESS  |  |   |                              |                            |  |
|   |  |  |  |  |                   | 5800 Edmondson Avenue   |  |   |                              |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)   |  |   |                              |                            |  |
| Burial  |  | Aug. 26, 1968  |  | Holy Redeemer  |                   | Baltimore, Maryland   |  |   |                              |                            |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                   | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |                              | 25b. REGISTRAR'S SIGNATURE |  |
| Witzke, 4101 Edmondson Ave., 21229  |  |  |  |  |                   |   |  | AUG 26 1968   |                              | [Signature]                |  |

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PICK UP BY: **BB Barranco Funeral Home**

Gov. Ritchie Highway, Balto. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

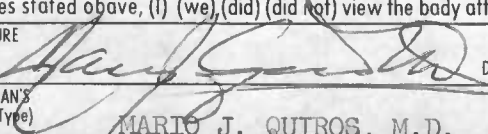
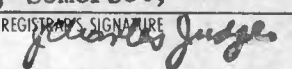
VR A15 (4-68)  
30M REV. 1-7-68

11105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11113

|  |  |   |                        |   |   |   |   |   |
|--|--|---|------------------------|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>ARTHUR</b>  | Middle<br><b>JAMES</b> | Last<br><b>GARDNER</b>  | 2a. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>24</b> Year <b>1968</b> |   | 2b. HOUR<br><b>8:50AM</b>   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |                        | 5. DATE OF BIRTH<br><b>9/18/1894 1895</b>   |   | 6. AGE (In years last birthday)<br><b>73 72</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration Hospital</b> |                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Baker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Somerset</b>  |                        | 13c. CITY OR TOWN<br><b>Crisfield</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>21 Franklin Lane</b>   |
| 14. FATHER'S NAME<br><b>Frank</b>  |  | First<br><b>Gardner</b>   |                        | Last<br><b>Maggie</b>   |   | 15. MOTHER'S MAIDEN NAME<br><b>Savage</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>Yes</b>  |  | (If yes give war or dates of service)<br><b>WW I</b>  |                        | 16b. SOCIAL SECURITY NO.<br><b>215-18-4175</b>  |   | 17. INFORMANT<br><b>Clin. Rec. VAH, Fort Howard, Maryland</b>                                   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |                        |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>YEARS</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200 CHRONIC PULMONARY EMPHYSEMA</b>  |  |   |                        |   |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>                 |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |                        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17/1968</b> , to <b>8/24/1968</b> , that (I) (we) lost saw the deceased alive on <b>8/24/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                        |   |   |   |   |   |
| 22b. SIGNATURE<br>  |  | DEGREE<br><b>M.D.</b>   |                        | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |   | 22c. DATE SIGNED<br><b>8/25/68</b>  |   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARIO J. QUIROS, M.D.</b>   |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |                        |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug. 27, 1968</b>   |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mariners Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Crisfield, Somerset, Md.</b>                |   |   |
| 24. FUNERAL DIRECTOR<br><b>Bradshaw Funeral Home</b>   |  |   |                        | ADDRESS<br><b>Crisfield, Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 29 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 11106  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 11114  |  |                          |  |  |  |
|--|--|--|--|---|--|--|--|--------------------------|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                          |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |  |
| MYRNA  |  | NELSON   |  | DORMAN  |  | GIBBS  |  | AUGUST 10, 1968          |  | 12:45M                                       |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                             |  |
| FEMALE   |  | WHITE  |  | SEPTEMBER 7, 1923   |  | 44 YRS.  |  | MONTHS                   |  | DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                          |  |  |  |
| HARRISONBURG, VA.  |  | U.S.A.   |  |   |  | Baltimore  |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |  |  |
| TOWSON #4  |  | ST. JOSEPH HOSPITAL  |  | Accountant  |  | Gen. Business  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |
| MARYLAND   |  | BALTIMORE  |  | Roseale   |  |  |  | 1908 WILHELM AVE. #37    |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |  |
| Roy  |  | DORMAN   |  | CARL  |  |  |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |                          |  |  |  |
| No   |  | 231 14 9076  |  | William H. Gibbs  |  | 1908 Wilhelm Ave   |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u><br><u>180X</u> DUE TO, OR AS A CONSEQUENCE OF <u>carcinoma of cervix and uterus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____  |  |  |  |   |  |  |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>171X</u>   |  |  |  |   |  |  |  |                          |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                          |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                          |  |  |  |
| 22a. I certify that <u>180X</u> (this hospital) attended the deceased from <u>August 8</u> , 19 <u>68</u> , to <u>August 10</u> , 19 <u>68</u> , that <u>10</u> (we) last saw the deceased alive on <u>August 10</u> , 19 <u>68</u> , and that in (my) <u>100X</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                          |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |                          |  |  |  |
| T. Villa   |  | August 10, 1968  |  | Lope Villa, M. D.   |  | 7620 York Road, Towson 4, Md.  |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                          |  |  |  |
| Burial   |  | 8-13-68  |  | GARDENS OF FAITH Cemetery   |  | Baltimore, Md.   |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REC'D BY STATE HEALTH DEPT.   |  |                          |  |  |  |
| Philip E. Cruch  |  | 1211 Chesapeake Ave.   |  | DATE AUG 13 1968  |  | John J. Judge  |  |                          |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11107

CERTIFICATE OF DEATH

11115

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Gerard Gregory GIBSON</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>20</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>12 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>June 10, 1912</b>  |  | 6. AGE (In years last birthday)<br><b>56</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>ORGANIZER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TEAMSTERS UNION # 311</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |
| 13e. STREET AND NUMBER<br><b>5511 Todd Ave.</b>   |  | 14. FATHER'S NAME First Middle Lost<br><b>John P. GIBSON</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Lost<br><b>MARY A. HAGERTY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-032211</b>  |  | 17. INFORMANT (BROTHER)<br><b>MR. JOSEPH F. GIBSON 4114 RAYMOND AVE.</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute gastrointestinal bleeding</b><br><b>1531</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mutliple stress ulcers of stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Post operative status partial colectomy for</b><br>adeno carcinoma of transverse colon                          |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>8/15/68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gastric enteritis</b>                               |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/12/</b> , 19 <b>68</b> , to <b>8/20/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>8/20/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>August 20, 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lawrence J. Misanik, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-24-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDIENS OF FAITH</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO., Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>J. Walter Conklin 5444 BELAIR ROAD</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 26 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |



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EXHIBIT OF DEATH

11107  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

11112  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

11113  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

11114  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

11115  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |  |  |
| 111106   |  |  |  |   |  |  |  |  |  |
| 111116   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   | 2a. DATE OF DEATH                      |  |  | 2b. HOUR   |  |
| First Middle Last<br><b>WILLIAM MC KENZIE GIBSON</b>   |  |  |  |   | Month Day Year<br><b>AUGUST 3 1968</b> |  |  | 9:50aM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| <b>MALE</b>  |  | <b>WHITE</b>   |  | <b>JUNE 27, 1889</b>  |  | <b>79</b>  |  | YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH  |  |
| <b>MARYLAND</b>  |  | <b>U.S.A.</b>  |  |   |  | <b>BALTIMORE</b>   |  | <b>TOWSON 4</b>  |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                      |  | 13b. COUNTY  |  |
| <b>ST. JOSEPH HOSPITAL</b>   |  | <b>RETIRED - construction</b>  |  | <b>STEEL</b>  |  | <b>MARYLAND</b>  |  | <b>BALTIMORE</b>   |  |
| 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER  |  | 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |
| <b>BALTIMORE</b>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  | <b>1 ORKNEY COURT #12</b>   |  | First Middle Last<br><b>George Gibson</b>  |  | First Middle Last<br><b>Mary McCormick</b>                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)    |  |
| <b>No</b>  |  | <b>037-09-1167</b>   |  | <b>Hospital Records</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic coma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cirrhosis of the liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  | <b>571.9</b>   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  | <b>5810</b>  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |
|  |  |  |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>July 29, 1968</b> , to <b>August 3, 1968</b> , that (I) (we) lost saw the deceased alive on <b>August 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  | 22b. SIGNATURE<br><i>Beatriz Dizon M.D.</i>  |  | 22c. DATE SIGNED<br><b>August 3, 1968</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Beatriz Dizon, M. D.</b>  |  | 22e. ADDRESS<br><b>7620 York Road, Towson 4, Maryland</b>                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  | 24. FUNERAL DIRECTOR   |  |
| <b>Burial</b>  |  | <b>8-6-68</b>  |  | <b>Lake View</b>  |  | <b>Carroll Md.</b>   |  | <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd., Bal</b>                        |  |
| 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE  |  | 25d. REGISTRAR'S SIGNATURE   |  | 25e. REGISTRAR'S SIGNATURE   |  |
| <b>AUG 5 1968</b>  |  | <i>[Signature]</i>   |  | <i>[Signature]</i>  |  | <i>[Signature]</i>   |  | <i>[Signature]</i>   |  |

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CHURCH OF THE

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11109

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11117

|  |         |   |        |   |   |   |                           |  |                                   |   |  |
|--|---------|---|--------|---|---|---|---------------------------|--|-----------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First   | Middle | Last  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |   | Month                     | Day  | Year                              | 2b. HOUR  |  |
| NORMAN   |         |   |        | GIFFORD   | Aug. 17                                   |   | 19                        | 68   |                                   | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS                 |   | IF UNDER 24 HRS.<br>HOURS |  | 2c. DATE PRONOUNCED DEAD<br>Month |   |  |
| male   | white   | 5/24/13   |        | 55 1/2 YRS.   |   |   |                           |  | Day                               |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH  |                           | 2d. HOUR   |                                   | M   |  |
| New Jersey   |         | U.S.A.  |        |   |   | Baltimore   |                           |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                           |  |                                   |   |  |
| Rosedale   |         | 1916 Wilhelm Ave.   |        | Dock Loader-Preston   |   |   |                           |  |                                   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 13e. STREET AND NUMBER   |                                   |   |  |
| Md.  |         | Balto.  |        | Baltimore   |   |   |                           | Trucking Co.<br>916 Kenwood Ave.   |                                   | 21205   |  |
| 14. FATHER'S NAME  |         | First   | Middle | Last  | 15. MOTHER'S MAIDEN NAME                  |   | First                     | Middle   | Last                              |   |  |
| Harvey Gifford   |         |   |        |   | Martha Murphy                             |   |                           |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |   | ADDRESS   |                           |  |                                   |   |  |
| no   |         | 213-01-7254   |        | Norman Gifford, son,  |   | 1916 Wilhelm Ave.   |                           |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Lung &amp; Met.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |   |        |   |   |   |                           |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>163X</u>  |         |   |        |   |   |   |                           |  |                                   |   |  |
| 19a. DATE OF OPERATION   |         |   |        | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |   |                           | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |   |        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. _____ 19 _____   |   |   |                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |        | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   |   |   |                           | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |        |   |   |   |                           |  |                                   |   |  |
| ACTUAL SIGNATURE <u>Theo C Patterson</u>   |         |   |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |                           | 22b. DATE SIGNED <u>8/19/68</u>  |                                   |   |  |
| EXAMINER'S NAME (Type) <u>THEO. C PATTERSON</u>  |         |   |        | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |                                   |   |  |
|  |         |   |        | ADDRESS (Street, city, town, or county)   |   |   |                           |  |                                   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |                           | (County)   |                                   | (State)   |  |
| Burial   |         | 8/20/68   |        | Parkwood Cemetery   |   | Baltimore, Md.  |                           |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane   |         |   |        |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 20 1968</u>  |                           | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Young</u>                                |                                   |   |  |

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UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |   |  |  |                                |  |                                |  |  |
|--|--|--|---|---|---|---|---|--|--|--------------------------------|--|--------------------------------|--|--|
| 111110   |  |  |   |   | CERTIFICATE OF DEATH  |   |   |  |  | 111118                         |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>(Thomas) T. M. Ginn</b>  |  |  |   |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>3</b> Year <b>1968</b>   |   |   |  |  | 2b. HOUR<br><b>M</b>           |  |                                |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cau.</b>   |   | 5. DATE OF BIRTH<br><b>3-26-1922</b>  |   |   | 6. AGE (In years last birthday)<br><b>46</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |                                |  | Md.                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fullerton</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4100 Asbury Avenue</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Spot Welder</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b> |                                |  | Md.                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Fullerton</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4100 Asbury Avenue 36</b>   |                                |  |                                |  |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Amoss</b> Last <b>Ginn</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Bora</b> Middle <b>J.</b> Last <b>Pearson</b>  |   |   |  |  |                                |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>256-14-8577</b>  |   | 17. INFORMANT<br>Address<br><b>Mrs Helen V. Ginn 4100 Asbury Avenue 36</b>  |   |   |  |  |                                |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>157.9</b><br><b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intoxication due to Pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |   |   |  |  |                                |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>157X</b>   |  |  |   |   |   |   |   |  |  |                                |  |                                |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |   |  |  |                                |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |                                |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |  |  |                                |  |                                |  |  |
| 22b. SIGNATURE<br><b>Dr. Harris</b>  |  |  |   |   | DEGREE ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/5/68</b>   |  |  |                                |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Harris</b>  |  |  |   |   | 22e. ADDRESS<br><b>8100 Harford Road</b>  |   |   |  |  |                                |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-5-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b>                       |  |  |                                |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7401 Belair Road 21236</b>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>AUG 6 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>   |  |  |                                |  |                                |  |  |

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*Handwritten signature or text, possibly "J. H. H. H."*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |   |     |  |                            |
|--|--|---|--|---|--|---|--|---|-----|--|----------------------------|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |     |  |                            |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>JAMES</b>   |  | Middle<br><b>JOSEPH</b>   |  | Last<br><b>GIRARDI</b>  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>1</b> Year <b>68</b> |     |  | 2b. HOUR<br><b>7:30A</b> M |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>5/6/04</b>   |  | 6. AGE (In years last birthday)<br><b>64</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                  |     | IF UNDER 24 HRS.<br>HOURS MIN.               |                            |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PHILADELPHIA, PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |   | Md. |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PIPEFITTER HELPER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HUMBLE OIL COMPANY</b>                                  |  |   |     |  |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>116 S. BROADWAY</b>                |     |  |                            |
| 14. FATHER'S NAME<br>First <b>CARMEN</b> Middle <b></b> Last <b></b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>MARGARET</b> Middle <b>DI</b> Last <b>FLIPPO</b>                     |  |   |  |   |  |   |     |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give dates of service)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216 03 95 00</b>   |  | 17. INFORMANT<br>Address<br><b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |   |  |   |     |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA AND PULMONARY CONGESTION</b><br><b>188X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>TERMINAL CARCINOMA OF BLADDER WITH GENERALIZED METASTASES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |  |   |  |   |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>1810</b>  |  |   |  |   |  |   |  |   |     |  |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |     |  |                            |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |     |  |                            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |     |  |                            |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/25/68</b> , 19 <b>68</b> , to <b>8/1/68</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>8/1/68</b> , 19 <b>68</b> , and that in <del>his</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |     |  |                            |
| 22b. SIGNATURE<br><i>Howard C. Kramer</i>  |  | DEGREE<br><b>HOWARD C. KRAMER, M. D.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/1/68</b>   |  |   |     |  |                            |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |  |   |  |   |     |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/5/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIOAL</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |   |     |  |                            |
| 24. FUNERAL DIRECTOR   |  | ADDRESS<br><b>Schimunek Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 5, 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |     |  |                            |

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1. 2. 3. 4.

DATE: 10/11/1967

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TABLE 1

FOR THE YEAR 1961

PAULINE BROWNE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <i>Russell</i> First <i>Z.</i> Middle <i>Goode</i> Last  |   |   | 2a. DATE OF DEATH<br>Month <i>8</i> Day <i>22</i> Year <i>68</i>                                |  | 2b. HOUR<br>M   |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br><i>Jan. 6-1895</i>  |   | 6. AGE (In years last birthday)<br><i>73</i> YRS.      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Cherryville N.C.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br>—   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>2217 Westchester Ave</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Retired</i>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Army-Air Force</i>                                      |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  | 13b. COUNTY<br><i>Balto.</i>  | 13c. CITY OR TOWN<br>—  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><i>2217 Westchester Ave.</i> |   |
| 14. FATHER'S NAME<br><i>Thomas V.</i> First <i>Goode</i> Middle Last   | 15. MOTHER'S MAIDEN NAME First <i>Georgia</i> Middle Last <i>Brown</i>                                      |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>YES</i> (If yes give year or dates of service)<br><i>World War I.</i>  | 16b. SOCIAL SECURITY NO.<br>—   | 17. INFORMANT<br><i>Mr. Vance S. Goode</i> Address <i>207 Hampton Road MANASSAS, VA. 22110</i>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>1990 metastatic Carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>to brain, lungs, liver, bones.</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><i>1992</i>   |   |   |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-21-65</i> 19 <i>65</i> , to <i>7-23</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 23</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><i>[Signature]</i>   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      | 22c. DATE SIGNED  |  |   |
| 22d. PHYSICIAN'S NAME (Type)   |   | 22e. ADDRESS  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br><i>8/26/68</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>Woodlawn Md.</i>                            |  |   |
| 24. FUNERAL DIRECTOR<br><i>Loring Byers - 8728 Liberty Road</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>AUG 26 1968</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 11113   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 11121  |  |
| 1. DECEASED-NAME (Type or print)  |  |   |  |   |  | 2a. DATE OF DEATH  |  |
| First<br>GEORGE   |  | Middle<br>WILLIAM   |  | Last<br>GOSKER, JR.   |  | Month Day Year<br>AUGUST 13 1968   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>JULY 7, 1921  |  | 6. AGE (In years birth day) 47   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VETERANS ADMINISTRATION HOSP.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>TRUCK DRIVER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OIL COMPANY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>8424 HALLMARK AVENUE  |  | 14. FATHER'S NAME First Middle Last<br>GEORGE WILLIAM GOSKER, SR.   |  |   |  |  |  |
| 15. MOTHER'S MAIDEN NAME First Middle Last<br>MOLLY RENNER  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (or unknown) <input type="checkbox"/> (If yes give year or dates of service)<br>WWII |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>213 12 0967   |  | 17. INFORMANT Address<br>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 189.0 HYPERNEPHROMA WITH WIDE SPREAD METASTASIS TO LUNG AND BRAIN<br>DUE TO, OR AS A CONSEQUENCE OF SEVERE ANEMIA, SECOND TO NUMBER ONE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 MONTHS<br>6 MONTHS                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>180X  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from July 31, 1968, to August 13, 1968, that (b) (we) last saw the deceased alive on August 13, 1968, and that in (c) (my) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>RODOLFO G. MIRO, M. D.  |  | 22c. DATE SIGNED<br>8 13 68   |  | 22d. PHYSICIAN'S NAME (Type)<br>VAH, FORT HOWARD, MARYLAND  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br>BURIAL  |  | 23b. DATE<br>8-16-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                         |  |
| 24. FUNERAL DIRECTOR<br>Chas. F. Evans & Son  |  | 24a. REC'D BY REGISTRAR<br>DATE AUG 14 1968   |  | 24b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |       |   |  |   |   |                                   |                               |
|---|--|--|-------|---|--|---|---|-----------------------------------|-------------------------------|
| 111114<br>CERTIFICATE OF DEATH  |  |  |       |   |  |   |   |                                   |                               |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |   |                                   | 2b. HOUR                      |
| Lucy  |  |  | Ann   | Green   |  | Aug. 17 1968  |   |                                   | 11 P M                        |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS    |                               |
| Female  |  | Negro  |       | July 4, 1885  |  | 83 YRS.   |   |                                   |                               |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                                   | Md.                           |
| Maryland  |  | U.S.A.   |       |   |  | Baltimore County  |   |                                   |                               |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                               |
| Catonsville   |  | Spring Grove State Hospital  |       |   |  |   |   |                                   |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |   | 13e. STREET AND NUMBER            |                               |
| Maryland  |  | Prince Georges's   |       | County  |  |   |   | Rt. 197, Mitchellville, Md.       |                               |
| 14. FATHER'S NAME<br>(dec'd)  |  |  | First | Middle  | Last   | 15. MOTHER'S MAIDEN NAME<br>(dec'd)   |   |                                   | First Middle Last             |
|   |  |  |       |   |  |   |   |                                   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | (If yes give war or dates of service)  |       | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |   |                                   |                               |
|   |  |  |       | 219-54-8979   |  | Records: Spring Grove State Hospital  |   |                                   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intestinal rebellion hemorrhage</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days years |  |  |       |   |  |   |   |                                   |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221  |  |  |       |   |  |   |   |                                   |                               |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |                                   |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |                                   |                               |
|   |  |  |       |   |  |   |   |                                   |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from August 6, 1968, to Aug. 17, 1968, that (I) (we) last saw the deceased alive on 8-17-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |       |   |  |   |   |                                   |                               |
| 22b. SIGNATURE<br>W A Deane MD  |  |  |       |   | DEGREE<br>MD   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br>18 Aug 68 |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |       |   | 22e. ADDRESS   |   |   |                                   |                               |
| W A DEANE JR MD   |  |  |       |   | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                             |   |   |                                   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |                                   |                               |
|   |  | 8-22-68  |       | Germans men Park  |  | Highland Park Md  |   |                                   |                               |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |       |   | 25a. REC'D BY REGISTRAR<br>DATE  |   | 25b. REGISTRAR'S SIGNATURE  |                                   |                               |
| H S Washington & Sons 4925 Deane ave NE   |  |  |       |   | AUG 22 1968  |   | Charles Judge   |                                   |                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/78

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>Lelia</b>  |  |  | Middle<br><b>Greenbaum</b>  |  |  | Last<br><b>Greenbaum</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>27</b> Year <b>68</b> |   |  | 2b. HOUR<br><b>9:15</b> AM              |  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>Nov. 16, 1879</b>  |  |  | 6. AGE (in years<br>last birthday)<br><b>88</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |   |  | IF UNDER 24 HRS.<br>HOURS MIN.          |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Balto., Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville, Md.</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>College Manor<br/>300 W. Seminary Ave.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>304 St. Dunstons Rd.</b>            |   |  |   |  |  |  |
| 14. FATHER'S NAME<br><b>Frederick</b>   |  |  | First<br><b>Frederick</b>  |  |  | Middle<br><b>Strodtman</b>  |  |  | Last<br><b>Eleanor</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Hempel</b>                        |   |  | First<br><b>Hempel</b>                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>79450</b>  |  |  | 17. INFORMANT<br><b>Mr. R. Phillips, Md. Nat'l Bank,</b>  |  |  | Address<br><b>Balto., Md.<br/>21203</b>                          |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Prnauvone</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>AS CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Year</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>  |  |  |  |  |  |   |  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1961</b> to <b>Aug 27, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>8-19-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.                           |  |  |  |  |  |   |  |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>RK Gundry</b>  |  |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/>   |  |  | MED.<br>DIRECTOR <input type="checkbox"/>   |  |  | STAFF<br>PHYS. <input type="checkbox"/>                          |   |  | 22c. DATE SIGNED<br><b>Aug 27, 1968</b> |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Richard K. Gundry, M. D.</b>  |  |  | 22e. ADDRESS<br><b>2 W. University Parkway, Balto., Md. 21218</b>  |  |  |   |  |  |   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>8/28/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Hebrew Cem.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |  |  |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Tickner - North &amp; Pennsylvania Aves.</b>  |  |  |  |  |  | 25a. BY REQUEST<br>DATE<br><b>SEP 2 1968</b><br><b>8/28/68</b>  |  |  | 25b. REGISTER'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |   |  |   |  |  |  |

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## CERTIFICATE OF DEATH

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ANNIE</b> <b>MAY</b> <b>GUILLOTT</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>25</b> Year <b>1968</b>       |   |  | 2b. HOUR<br><b>5:30 A.M.</b>  |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br><b>August 31, 1883</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>84</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Rosewood State Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>none</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>none</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Harford</b>  |   | 13c. CITY OR TOWN <b>Bellini</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>109 N. Main St.</b> |  |
| 14. FATHER'S NAME First <b>Eugene</b> Middle <b>S.</b> Last <b>Guillott</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>Ella</b> Middle <b>M.</b> Last <b>Jones</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-54-0253</b>                                |   | 17. INFORMANT<br><b>Mr. Walter McSherry</b> Address <b>523 S. Main St. Md.</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>315X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure + Cerebro Vascular</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Mental Retardation Under Etiology with Hypertension</b><br>Accident<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>3255</b>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Nov. 17</b> , 19 <b>58</b> , to <b>Aug. 25</b> , 19 <b>68</b> , that (1) (we) lost<br>saw the deceased alive on <b>August 25</b> , 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the<br>causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lucrecia F. Joven, M.D.</b> DEGREE   |  |   |   | ATTENDING<br>PHYS. <input type="checkbox"/> MED. <input checked="" type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-25-68</b>  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Lucrecia F. Joven, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>Owings Mills, Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><b>8/28/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hickory</b>  |  | 23d. LOCATION (City or Town)<br><b>Bellini Md.</b>  |  | (County) (State)                                 |  |
| 24. FUNERAL DIRECTOR<br><b>William H. Hardey, Jr. Md.</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 30 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR 1514  
30M REV. 3/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |   |   |  |  |  |
|--|--|---|---|---|---|---|--|--|--|
| 111125<br>CERTIFICATE OF DEATH   |  |   |   |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Frederick Clarence</b>   |  |   | First Middle Last<br><b>HAMILTON</b>                                |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>8/ 17 68</b>  |  | 2b. HOUR<br><b>3:00PM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br><b>9/29/93</b>  |   | 6. AGE (In years last birthday)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMIN. HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TRACK FOREMAN</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>HOWARD</b>  |   | 13c. CITY OR TOWN<br><b>HANOVER</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>RFD 2, BOX 18</b>                   |  |
| 14. FATHER'S NAME First Middle Last<br><b>WILLIAM - - HAMILTON</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>LEAH - - ADAMS</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWI</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>705 07 58 03</b>                     |   | 17. INFORMANT Address<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____             |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b>     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>BENIGN PROSTATIC HYPERTROPHY</b>   |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that <b>41</b> (this hospital) attended the deceased from <b>JUL 25</b> , 19 <b>68</b> , to <b>AUG 1</b> , 19 <b>68</b> , that <b>41</b> (we) last saw the deceased alive on <b>AUG 1</b> , 19 <b>68</b> , and that in <b>41</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>41</b> (we) (did) <b>(not see)</b> view the body after death. |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Madhav Barhanpurkar</b> DEGREE  |  |   |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/1/68</b>                                    |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV BARHANPURKAR, M.D.</b>   |  |   |   |   | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/5/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEMETERY</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>HERBERT NUTTER FUN. DIR. 3035 W. NORTH AVE. BALTO., MD.</b>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 11118  |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |  |  | 11126  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 1. DECEASED-NAME<br>(Type • print)   |  |  |  |  |  |  |  |  |  |  |  | First<br>HENRY   |  |  |  |  |  |   |  |  |  |  |  | Middle<br>JEROME                                 |  |  |  |                                |  |     |  |  |  |  |  | Lost<br>HANLIN |  |  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>8 Month 1 Day 68 Year |  |  |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>9AM.M |  |  |  |
| 3. SEX<br>MALE   |  |  |  |  |  | 4. RACE<br>WHITE   |  |  |  |  |  | 5. DATE OF BIRTH<br>August 27- 1909  |  |  |  |  |  | 6. AGE (In years<br>lost birthday)<br>38 YRS.   |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) W. Va.  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  | 9. COUNTY OF DEATH<br>BALTIMORE   |  |  |  |  |  |  |  |  |  |                                |  | Md. |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GR. BALT. MED. CENTER |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Janitor, Bethlehem Steel Co.   |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  | 13c. CITY OR TOWN<br>Dundalk   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  | 13e. STREET AND NUMBER<br>306 Pinewood Rd. 21222 |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 14. FATHER'S NAME<br>First Middle Lost<br>Stewart A. Hanlin  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br>Anna Charlotte Agnew                                    |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give year or dates of service)<br>Yes. Army 1943-45  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>546-09-2722  |  |  |  |  |  | 17. INFORMANT<br>Address<br>Wife, Mrs. Selma V. Hanlin, #13, a, b, c, d, e.  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br><u>1621</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CA OF THE LUNG &amp; EMPHYSEMA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>163x</u> ARTERIO SCLEROTIC HEART DISEASE   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
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| 19a. DATE OF OPERATION   |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>68</u> , to <u>8/1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/1</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>Derek A. Bruce</u><br>DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.<br>22d. PHYSICIAN'S NAME (Type) DEREK A. BRUCE, MD.  |  |  |  |  |  | 22c. DATE SIGNED<br><u>8/1/68</u>   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 22e. ADDRESS<br>GBMC   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  |  |  |  | 23b. DATE<br>Aug. 5-1968   |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn   |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, Dundalk, Maryland 21222  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DAUG 2 1968   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |  |  |  |  |  |                                |  |     |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1968

| 11119  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   | 11127  |  |
|--|---|---|---|--|--|
| CERTIFICATE OF DEATH   |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Elizabeth M. Hardy</i>  |   |   | 2a. DATE OF DEATH<br>Month <i>August</i> Day <i>10</i> Year <i>1968</i>   |  | 2b. HOUR<br><i>11:45</i> M                                       |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br><i>Sept. 16, 1876</i>   |   | 6. AGE (In years last birthday)<br><i>91</i> YRS.                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Ohio</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md. <i>21228</i>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>333 Harlem Lane</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At home</i>              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>  | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                | 13e. STREET AND NUMBER<br><i>2533 Pickwick Rd</i> <i>21207</i>         |  |
| 14. FATHER'S NAME First <i>Andrew</i> Middle <i>Kuhl</i> Last <i>Kuhl</i>  | 15. MOTHER'S MAIDEN NAME First <i>Marie</i> Middle <i>Wagner</i> Last <i>Wagner</i>                     |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown <i>No</i> (If yes give war or dates of service) |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>712-18-6769</i>   |   | 17. INFORMANT Address<br><i>Dr. Wm. Hardy 2533 Pickwick Rd 21207</i>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>10 years</i> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>48 hours</i>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>4201</i>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                     |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>65</i> , to <i>August</i> , 19 <i>68</i> , that (I) (we) saw the deceased alive on <i>August 10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Millard T. Traband M.D.</i>   |   | 22c. DATE SIGNED<br><i>8/10/68</i>  | 22d. PHYSICIAN'S NAME (Type)<br><i>Millard T. Traband M.D.</i>  |  |  |
| 22e. ADDRESS<br><i>1811 N. Rolling Rd Baltimore Md 21207</i>   |   | 22f. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>  | 23b. DATE<br><i>8/12/68</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenmount</i>   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br><i>6212 Baltimore National Pike Wm. Cook-Brooks West Inc Balt. Md. 21228</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>AUG 13 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                     |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

111120

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

111128

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>David Rogerson Williams Harrison</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>20</b> Year <b>1968</b>   |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>June 16, 1908</b>  |   | 6. AGE (In years lost birthday)<br><b>60</b> YRS. | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN.                        |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Howard Co., Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore Co.</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrison, Md.</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Garrison, Md.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Insurance Broker</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hall &amp; Harrison</b>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Baltio.</b>  | 13c. CITY OR TOWN<br><b>Garrison</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 | 13e. STREET AND NUMBER<br><b>Garrison, Md.</b>    |  |
| 14. FATHER'S NAME<br>First <b>Robert</b> Middle <b>Barker</b> Last <b>Harrison Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Virginia</b> Middle <b>Elizabeth</b> Last <b>White</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>212-20-0342</b>   | 17. INFORMANT<br>Address <b>Mrs. Dorthy N. Harrison, Garrison, Maryland</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cor pulmonale</b><br><b>492X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                    |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 yrs</b><br><b>Few years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><b>5271</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1949</b> , 19 <b>Aug 20</b> 19 <b>68</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>19 Aug</b> 19 <b>68</b> , and that in (my) <b>(op)</b> opinion a death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Paul H. Royse</b>   |  | DEGREE <b>MD</b>  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>21 Aug 68</b>              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Paul H. Royse MD</b>  |  | 22e. ADDRESS<br><b>1403 Foley Lane Pikesville, Md.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Aug. 22, 1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Thomas Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Garrison Forrest, Baltio, Md.</b>   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Frank St. Newell, Pikesville, Md.</b>   |  | ADDRESS<br><b>21206</b>   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 23 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

• *Journal of the American Medical Association*, 2000; 283: 2639-2644

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11122

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11129

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Edwin H. Hedrick</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>August</i> Day <i>16</i> Year <i>1968</i>                    |   |  | 2b. HOUR<br><i>2A</i> M  |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>September 26, 1914</i>   |  | 6. AGE (In years lost birthday)<br><i>53</i> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Arbutus</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>3606 Ashbourne Rd.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Engineer</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Construction</i>                                     |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>   |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Arbutus</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>3606 Ashbourne Rd.</i> |  |
| 14. FATHER'S NAME First <i>Henry</i> Middle <i>Hedrick</i> Last <i>Hedrick</i>  |  |   | 15. MOTHER'S MAIDEN NAME First <i>Lena</i> Middle <i>Hundermark</i> Last <i>Hundermark</i> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>216-09-6355</i>  |  | 17. INFORMANT<br><i>Catherine Hedrick</i>   |  | Address<br><i>3606 Ashbourne Rd</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma floor 7 mouth tongue. 11 mo</i><br><i>144 X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                   |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>1992</i>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 30</i> , 19 <i>67</i> , to <i>Aug 15</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Aug 15</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>A. Bradley Dougherty MD</i>  |  |   |  | DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |  | 22c. DATE SIGNED<br><i>Aug. 16, 1968</i>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>A. Bradley Dougherty</i>   |  |   |  | 22e. ADDRESS<br><i>1014 Francis Ave</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>9/19/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Dorsey Maryland</i>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Ambrose INC 1328 Sulphur Sp Rd.</i>  |  |   |  | 25a. REC'D BY REGISTRAR<br><i>Aug 21 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11122

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11130

## CERTIFICATE OF DEATH

|  |  |   |   |   |   |   |  |  |                                      |                               |                                    |  |
|--|--|---|---|---|---|---|--|--|--------------------------------------|-------------------------------|------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>HEENIG Z. HEER.   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>August 10 1968               |   |   | 2b. HOUR<br>10:08 PM  |  |  |                                      |                               |                                    |  |
| 3. SEX<br>FEMALE.  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MARCH 14 1880   |   | 6. AGE (In years last birthday)<br>88 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |                                      | IF UNDER 24 HRS.<br>HOURS MIN |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br>GERMANY   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE - CO Md.  |  |  |                                      |                               |                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Pocksville Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>MASSONIC HOME Cocksville Md |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSE WIFE   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                                      |                               |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Balt.  |   | 13c. CITY OR TOWN<br>Balt.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2702 Alameda Blvd. |                                      |                               |                                    |  |
| 14. FATHER'S NAME<br>First Middle Last<br>HERMAN E. KATT   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>VALENTINE Solinsky |   |   |   |  |  |                                      |                               |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>22-32-6792A                             |   | 17. INFORMANT<br>Address<br>RECORDS of MASSONIC HOME Cocksville Md.             |   |  |  |                                      |                               |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular accident<br>4369 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized cerebral arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days years |  |   |   |   |   |   |  |  |                                      |                               |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X   |  |   |   |   |   |   |  |  |                                      |                               |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                      |                               |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |                                      |                               |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |  | County                               |                               | State                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1968, to August 1968, that (I) (we) last saw the deceased alive on 10 August 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |  |  |                                      |                               |                                    |  |
| 22b. SIGNATURE<br>Walter T. Kees   |  |   | DEGREE  |   | ATTENDING PHYS.<br><input checked="" type="checkbox"/>                          |   | MED. DIRECTOR <input type="checkbox"/>                               |  | STAFF PHYS. <input type="checkbox"/> |                               | 22c. DATE SIGNED<br>10 August 1968 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>WALTER T. KEES   |  |   | 22e. ADDRESS<br>Cocksville, Md                                      |   |   |   |  |  |                                      |                               |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8-14-1968  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |   |   | 23d. LOCATION (City or Town)<br>Balt., Md.                           |  | (County)                             |                               | (State)                            |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson   |  |   |   | ADDRESS<br>1050 York Rd. Towson, Md. 21204  |   | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 15 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Young    |                                      |                               |                                    |  |

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MADE IN JAPAN

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11123

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11131

|   |                         |   |                          |   |   |   |  |
|---|-------------------------|---|--------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>Merrill</b>   | Middle<br><b>Richard</b> | Last<br><b>Heim</b>   | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <b>Aug.</b> Day <b>14</b> Year <b>1968</b> |   | 2b. HOUR<br><b>M</b>                         |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>July 2, 1913</b>   |                          | 6. AGE (In years last birthday)<br><b>55</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>   | IF UNDER 24 HRS<br>HOURS<br><b>0</b>  | MIN.<br><b>0</b>                             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7830 W. Collingham Rd.</b> |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Stock Clerk, Mercantile Safe &amp; Deposit Trust Co.</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |                          | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>7830 W. Collingham Rd.</b>   |                         |   |                          |   |   |   |  |
| 14. FATHER'S NAME<br>First<br><b>Clarence</b>   |                         | Middle<br><b>F.</b>   |                          | Last<br><b>Heim</b>   |   | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Edna</b>  |  |
| Middle<br><b>M.</b>   |                         | Last<br><b>Hess</b>   |                          |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>   |                         | (If yes give war or dates of service)<br><b>WWII</b>  |                          | 16b. SOCIAL SECURITY NO.<br><b>195-07-4181</b>  |   | 17. INFORMANT (Wife)<br><b>Mrs. Katherine G. Heim, 7830 W. Collingham Rd</b>                    |  |
| ADDRESS <b>Dundalk, Md.</b>   |                         |   |                          |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                         |   |                          |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b> <b>Edgious obesity</b>  |                         |   |                          |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>   |                          |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>—</b> P.M. <b>19</b>                                     |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>—</b>   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>—</b>                      |                          | 21f. LOCATION Street or R.F.D. No. <b>—</b>   |   | City or Town <b>—</b> County <b>—</b> State <b>—</b>  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><b>Theodore C. Patterson</b><br>ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b><br>M.D. <b>M.D.</b><br>22b. DATE SIGNED <b>Aug. 15, 1968</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) <b>Dundalk, Md. 21222</b> |                         |   |                          |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>8/19/68</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shoops Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Harrisburg, Dauphin Co. Pa.</b>             |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |   |                          | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 19 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

11131

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11124   |  |  |  |  |  |   |  |  |   | 11132  |  |   |  |  |                                   |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   | CERTIFICATE OF DEATH                         |  |   |  |  |                                   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Adam Charles Heriss</i>  |  |  |  |  | 2a. DATE OF DEATH<br>Month <i>Aug</i> Day <i>25</i> Year <i>68</i>                         |   |  |  |   | 2b. HOUR<br><i>9:25</i> M                    |  |   |  |  |                                   |  |  |  |  |
| 3. SEX<br><i>male</i>   |  |  | 4. RACE<br><i>white</i>  |  |  | 5. DATE OF BIRTH<br><i>7-31-89</i>  |  |  | 6. AGE (In years last birthday)<br><i>79</i> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>OAYS             |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore Co.</i> Md.  |  |  |   |  |  |                                   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catoonsville</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Summit Nursing Home</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Railroad</i>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Ret.</i>  |  |  |   |  |  |                                   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY<br><i>AA</i>   |  |  | 13c. CITY OR TOWN<br><i>Ferrisdale</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><i>6 Wells Ave.</i> |  |  |                                   |  |  |  |  |
| 14. FATHER'S NAME<br>First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i> |   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <i>no</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>213-32-9058</i>   |  |  | 17. INFORMANT<br>Address <i>Elmer Horsey, P.O. Box 425, Chestertown, Md.</i>  |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Septicemia</i><br><i>2509</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Bilateral gangrene of both legs</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Diabetes - severe arteriosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |                                   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>260x</i>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |                                   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> to <i>Aug 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 22b. SIGNATURE<br><i>Stanley Ankles</i>   |  |  | 22c. DATE SIGNED<br><i>8.25.68</i>   |  |  | 22d. PHYSICIAN'S NAME (Type)<br><i>STANLEY ANKLES</i>   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 22e. ADDRESS<br><i>1101 Maiden Choice La</i>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><i>28 Aug. 68</i>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Spring Hill Cemetery</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Easton, Maryland</i>                        |  |  |   |  |  |                                   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Kirkley Funeral Home, Glen Burnie, Md.</i>   |  |  | 25a. REC'D BY REGISTRAR<br><i>AUG 29 1968</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |   |  |  |   |  |  |                                   |  |  |  |  |

11138

REPORT OF DEATH

11138

Sex:

Married

X

AA

Unknown

Unknown

513-32-0033 Elmer Horney, P.O. Box 425, Chattertown, W.

no

Burial 28 Aug. 68 Spring Hill Cemetery, Madison, Maryland

Gravey Internal Home, Glen Burnie, Md.

FOR STATE  
HEALTH DEPT.

11125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11133

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Baltimore</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lawson</u>  |                                  | c. LENGTH OF STAY IN 1b <u>-</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hosp</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>William J.</u> Middle <u>J.</u> Last <u>Heller</u>   |                                  | 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1968</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>white</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH <u>1/21/1900</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>  |                                  | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>  |  |
| 13. FATHER'S NAME <u>Unknown</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                                  | 16. SOCIAL SECURITY NO. <u>207-29-3361</u>  |  |
| 17. INFORMANT <u>Wass Lillian Burns</u>   |                                  | Address <u>above</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4109</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) <u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u>   |                                  | INTERVAL BETWEEN ONSET AND DEATH <u>-</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE <u>Charles F. Donnell</u> M.D.   |                                  | 22. DATE SIGNED <u>8/28/68</u>  |  |
| EXAMINER'S NAME (Type)  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| Address (Street, city, town, or county)   |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>8/30/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>3801 Fredrick Ave Md.</u> |
| 24. FUNERAL DIRECTOR <u>John J. Cowan &amp; Son Inc.</u>  |                                  | 25a. REC'D BY REGISTRAR <u>92 Hollins St.</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>  |                                  | DATE <u>AUG 29 1968</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11133. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1110

UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11126  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11134                      |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|------------------|--|--|--|--|-------|--|--|--|--|------|--|--|--|--|
| Item#5 Film#G404 9/18/68 vmp   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Louise   |  |  |  |  | Hill   |  |  |  |  | Aug. 8, 1968   |  |  |  |  | 6:50 PM  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR            |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Female   |  |  |  |  | White  |  |  |  |  | Aug. 21, 1885  |  |  |  |  | 82 YRS.  |  |  |  |  | MONTHS                     |  |  |  |  | DAYS             |  |  |  |  | HOURS |  |  |  |  | MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| New Jersey   |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (give street address)                    |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Randallstown, Md.  |  |  |  |  | Randallstown Chapel Hill Nursing Home  |  |  |  |  | Secretary  |  |  |  |  | Jos. W. Graham   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER     |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Md.  |  |  |  |  | Baltimore  |  |  |  |  | Pikesville   |  |  |  |  |  |  |  |  |  | McHenry Ave.               |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| First Middle Last  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Jacob Hill   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| No   |  |  |  |  | None   |  |  |  |  | 150-10-4543  |  |  |  |  | Mrs. Clare Miller, McHenry Ave., Pikesville, Md.   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| IMMEDIATE CAUSE (a) Chronic myocarditis  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2 mos.   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary sclerosis  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2 mos.   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| (c) Art. Sclerosis   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2 yrs.   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 4201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
|  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION  |  |  |  |  | City or Town County State  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1966, to August 8, 1968, that (I) (we) last saw the deceased alive on Aug. 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| James A. Miller, M.D.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8/9/68   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. James A. Miller   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  | 22f. REGISTRAR'S SIGNATURE |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | McHenry Ave. Pikesville, Maryland 21208  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Burial   |  |  |  |  | Aug 10, 1968   |  |  |  |  | Arlington Cemetery   |  |  |  |  | Merchantville New Jersey   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |
| Frank H. Newell, Pikesville, Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE AUG 14 1968   |  |  |  |  | James J. Jago              |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |      |  |  |  |  |

11180

11134

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

1963 01 08

John W. Miller, Jr.  
Plaintiff  
vs.  
The United States  
Defendant

Case No. 11180

Filed for registration of a writ of habeas corpus.

On or about January 1, 1963, the Plaintiff filed a petition for a writ of habeas corpus.

The Court has considered the petition and the accompanying affidavits.

It is the order of the Court that the writ of habeas corpus be granted.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>11127</span> <span>CERTIFICATE OF DEATH</span> <span>11135</span> </div>  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>WILLIAM ROLAND HILL</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>16</b> Year <b>1968</b>  |  | 2b. HOUR<br><b>4:57AM</b>                                 |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>12/22/1889</b>   |  | 6. AGE (in years last birthday)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County Md.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Printer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Emerson Hotel</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET AND NUMBER<br><b>Emerson Hotel, Baltimore</b> |  |
| 14. FATHER'S NAME<br><b>William Hill</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Alice Simpson</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-0607</b>   |  | 17. INFORMANT Address<br><b>Records, Mt. Wilson State Hospital</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>492X Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema, chronic obstructive</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5271</b>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15/1968</b> , to <b>8/16/1968</b> , that (I) (we) lost saw the deceased alive on <b>8/16/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/20/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ebenezer Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Schiminek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 20 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |   |  |

1133

1134

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

TO THE  
HONORABLE  
MEMBERS OF THE  
NAVY

FROM THE  
SECRETARY OF THE  
NAVY

IN  
REPLY TO  
A LETTER  
FROM THE  
HONORABLE  
MEMBER OF THE  
NAVY

OF THE  
NAVY

OF THE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

11128

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11136

|   |  |   |       |   |      |  |  |  |                           |  |  |
|---|--|---|-------|---|------|--|--|--|---------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ALBERT</b>   |  |   | First | Middle  | Lost | 2a. DATE OF DEATH<br><b>8</b> Month <b>14</b> Day <b>68</b> Year   |  |  | 2b. HOUR<br><b>1 p.m.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |       | 5. DATE OF BIRTH<br><b>3-5-00</b>   |      | 6. AGE (In years last birthday)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |                           | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  | Md.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rendallstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore County Gen. Hosp</b> |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SGT.</b>  |      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>POLICE DEPT.</b>   |  |  |                           |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. CITY<br><b>Baltimore</b>   |       | 13c. CITY OR TOWN<br><b>Baltimore</b>   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>19 Warren Pk., APT. 3</b>               |                           |  |  |
| 14. FATHER'S NAME<br><b>LOUIS S. HOFFMAN</b>  |  |   | First | Middle  | Lost | 15. MOTHER'S MAIDEN NAME<br><b>ESTHER HOFFMAN</b>  |  |  | First Middle Lost         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | (If yes give war or dates of service)   |       | 16b. SOCIAL SECURITY NO.<br><b>214-40-8985</b>  |      | 17. INFORMANT <b>MRS. EMMA HOFFMAN</b> Address<br><b>19 WARREN PARK DR., APT. 3</b>  |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain Tumor with Increased Intracranial Pressure 5 mos</b><br><b>2381</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |       |   |      |  |  |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>237X ASCVD</b>   |  |   |       |   |      |  |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |  |  |  |                           |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |  |  |  |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-13</b> , 19 <b>68</b> , to <b>8-14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |       |   |      |  |  |  |                           |  |  |
| 22b. SIGNATURE<br><b>Jesus G. Santiano MD</b><br>DEGREE   |  |   |       |   |      | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-14-68</b>                                   |                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JESUS SANTIANO</b>   |  |   |       |   |      | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>   |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-15-68</b>   |       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ADATH JESHURUN</b>   |      | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>  |  |  |                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson 6010 Reisterstown Rd</b>  |  | ADDRESS<br><b>&amp; BROS. INC.</b>  |       | 25a. REC'D BY REGISTRAR<br>DATE<br><b>AUG 19 1968</b>   |      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |                           |  |  |

951-11

1994

1995

2001.11.15



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11129

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11137

|   |         |  |  |   |  |   |  |   |  |  |  |          |  |
|---|---------|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH                                     |  |  |  | 2b. HOUR |  |
| James Leroy Holzhauer, Jr.  |         |  |  |   |  |   |  | Month Day Year<br>August 6 1968                             |  |  |  | 8:46 PM  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |  | 2c. DATE PRONOUNCED DEAD                     |  | 2d. HOUR |  |
| Male  | White   | July 9, 1917   |  | 51 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  | Month Day Year<br>August 6 1968              |  | 8:46 PM  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |  |  |  |          |  |
| Virginia  |         | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |  |  |          |  |
| Towson  |         | St. Joseph's Hospital  |  | Accountant  |  | INDUSTRY  |  |   |  |  |  | C/O RR   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                                      |  |  |  |          |  |
| Maryland  |         | Baltimore  |  | Towson  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 811 Providence Road   |  |  |  |          |  |
| 14. FATHER'S NAME   |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME                                    |  | First  |  | Middle   |  |
| James Leroy Holzhauer, Sr.  |         |  |  |   |  |   |  | Mary Blanche Hagy   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |          |  |
| Yes   |         | 440 11   |  | Family records  |  |   |  |   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |  |  |          |  |
| 4109  |         |  |  | Sudden  |  |   |  |   |  |  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |          |  |
|   |         | (c)  |  |   |  |   |  |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         | 4201   |  |   |  |   |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: |         | Natural causes <input type="checkbox"/>                                      |  | Accident <input type="checkbox"/>   |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>                           |  | Undetermined manner <input type="checkbox"/> |  |          |  |
| ACTUAL SIGNATURE  |         | Charles F. O'Donnell, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                 |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED                             |  | 8/6/68   |  |
| EXAMINER'S NAME (Type)  |         | Charles F. O'Donnell, M.D.   |  | ADDRESS (Street, city, town, or county)   |  |   |  |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)  |  | (State)                                      |  |          |  |
| Removal   |         | Aug. 10, 1968  |  | Forest Lawn Cemetery  |  | Richmond, Virginia  |  |   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |          |  |
| John Burns' Sons, Towson, Maryland  |         |  |  | DATE AUG 12 1968  |  | Charles J. J...   |  |   |  |  |  |          |  |

RECEIVED THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1914

1914

RECEIVED THE SECRETARY OF THE ARMY

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WASHINGTON, D. C.

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RECEIVED THE SECRETARY OF THE ARMY

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WASHINGTON, D. C.

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |                                       |   |  |  |   |   |                             |  |
|---|--|--|---|--|---------------------------------------|---|--|--|---|---|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |                                       |   |  |  |   |   |                             |  |
| 11130 CERTIFICATE OF DEATH 11138  |  |  |   |  |                                       |   |  |  |   |   |                             |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Gertrude Katherine Hooper</b>  |  |  |   |  |                                       | 2a. DATE OF DEATH Month Day Year<br><b>Aug. 21, 1968</b>  |  |  | 2b. HOUR<br><b>6 a. M.</b>                            |   |                             |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>July 21, 1910</b>   |                                       |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                           |   | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |   |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (give street address)<br><b>Catonsville House In The Pines,</b> |  |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Practical-Nurse</b>               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-emp.</b> |   |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Edgewater</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rt. 4 Box 282</b>        |   |                             |  |
| 14. FATHER'S NAME First Middle Last<br><b>Charles Frank Crusey</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Eckenrode</b>  |                                       |   |  |  |   |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)<br><b>None</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-10-6692</b>   |                                       | 17. INFORMANT<br><b>Pikesville 8, Md. Mr. Albert Crusey, 704 Leafydale Terrace,</b>   |  |  |   |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |                                       |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>?</b><br><b>?</b> |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>331X Marked obesity</b>  |  |  |   |  |                                       |   |  |  |   |   |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |   |   |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.<br><b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                       |   |  |  |   |   |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                       |   |  |  |   |   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>68</u> , to <u>8-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                       |   |  |  |   |   |                             |  |
| 22b. SIGNATURE<br><u>Wilmer K. Gallagher M.D.</u> DEGREE  |  |  |   |  |                                       | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-23-68</b>   |   |   |                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Wilmer K. Gallagher</u>  |  |  |   |  |                                       | 22e. ADDRESS<br><u>6229 Frederick Br. Baltimore Md 21228</u>  |  |  |   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug 24, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |                                       |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Baltio. Md.</b> |   |   |                             |  |
| 24. PHYSICIAN DIRECTOR<br><u>Frank H. Newell, Pikesville, Md.</u>   |  |  |   |  |                                       | 25a. REC'D BY REGISTRAR<br><b>AUG 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                             |   |   |                             |  |

WESTERN HILLS OF TEXAS

111136

111136

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

Section 1, Township 10N, Range 10E, County 10S, State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |                                    |  |   |  |  |  |  |
|--|--|--|--|--|------------------------------------|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                                    |  |   |  |  |  |  |
| Item 6, telephone call Chesweth F. H. 9/4/68 cac   |  |  |  |  |                                    |  |   |  |  |  |  |
| 11139  |  |  |  |  |                                    |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |                                    |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |                                    | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |  |  |
| First MARY Middle CATHERINE Last HOPKINS   |  |  |  |  |                                    | Month 8 Day 21 Year 68   |   |  | 3:00a M  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |                                    | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday)  |  |  |
| Female   |  |  | Caucasian  |  |                                    | 2/27/23  |   |  | 46 1/2 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH   |  |  |
| Md.  |  |  | U.S.A.   |  |                                    |  |   |  | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  |
| Towson   |  |  |  | Greater Balto. Med. Center   |                                    |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.  |  |  |  |  |                                    | Balto.   |   |  |  | 4000 Roland Ave.                             |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  |                                    | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |  |  |  |
| ?  |  |  |  |  |                                    | ?  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no  |  |  |  |  |                                    | 16b. SOCIAL SECURITY NO. -----   |   | 17. INFORMANT Address  |  |  |  |
|  |  |  |  |  |                                    |  |   | Thomas Hopkins 1345 W. 42nd St.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                                    |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |                                    |  |   |  |  |  |  |
| IMMEDIATE CAUSE (a) 180 X Wide-spread carcinomatosis   |  |  |  |  |                                    |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |   |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |                                    |  |   |  |  |  |  |
| (b) Carcinoma of cervix  |  |  |  |  |                                    |  |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |   |  |  |  |  |
| (c)  |  |  |  |  |                                    |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |                                    |  |   |  |  |  |  |
| 171X   |  |  |  |  |                                    |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/8, 1968, to 8/21, 1968, that (I) (we) last saw the deceased alive on 8/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |   |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |                                    | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |                                    | 22e. ADDRESS   |   | 8/21/68  |  |  |  |
| Rudiger Breiteneker, M. D.   |  |  |  |  |                                    | Greater Baltimore Medical Center   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial   |  |  | 8/23/68  |  | Loudon Park                        |  |   | Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |                                    | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Paul E. Chenoweth Jr. 3617 Chestnut Ave.   |  |  |  |  |                                    |  |   | OATE AUG 26 1968   |  | J Charles Jurgis                             |  |

4000 Island Ave.

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**11132**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**11140**

|  |         |   |  |   |  |  |  |   |  |  |  |   |  |
|--|---------|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First   |  | Middle  |  | Last   |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-<br>DEATH MATED <input type="checkbox"/> |  | Month Day Year                             |  | 2b. HOUR  |  |
| MARY   |         | LEE   |  | HOWARD  |  |  |  |   |  | 19   |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  | 2d. HOUR  |  |
| female   | white   | 6/21/1929   |  | 39 YRS.   |  |  |  |   |  | August 18, 1968                            |  | 3:30 P. M.                                      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |  |  |   |  |
| Tennessee  |         | U.S.A.  |  |   |  | Baltimore  |  |   |  |  |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |  |  |   |  |
| Towson   |         | Greater Baltimore Medical   |  | Housewife   |  | Home   |  |   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |  |   |  |  |  |   |  |
| Maryland   |         | Baltimore   |  | Sparks  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | York Road   |  | Sparks, Maryland                           |  |   |  |
| 14. FATHER'S NAME First Middle Last  |         |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |  |  |   |  |  |  |   |  |
| Nile H. Miller   |         |   |  | Anna Sproles  |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |  |  |   |  |
| No   |         | ---   |  | 163-24-9403   |  | Kenneth L. Howard  |  | Sparks, Md.   |  | 21152                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u><br>5770<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |   |  |   |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>5870 <u>Fatty Alteration of the Liver</u>  |         |   |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL<br>SIGNATURE  |         | Werner U. Spitz, M.D.   |  | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br>8/19/68   |  |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |  |  |   |  |
| Burial   |         | 8/22/1968   |  | Bel Air Mem. Gardens  |  | Bel Air, Harford, Md.  |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR   |         |   |  | ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                 |  |   |  |
| Charles E. Kurtz   |         |   |  | Jarrettsville, Md.  |  |  |  | DATE  |  | AUG 21 1968                                |  |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 11133 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |                  |  |  |  |                                |   | 11141  |          |                          |  |          |  |
|---|--|---------|--|------------------|--|--|--|--------------------------------|---|--|----------|--------------------------|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |                  |  |  |  |                                |   |  |          |                          |  |          |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |         | First Middle Last  |                  |  | 2a. DATE KNOWN OF DEATH  |  |                                | Month Day Year  |  | 2b. HOUR |                          |  |          |  |
| FRANK   |  |         | E  |                  |  | HUET Jr.   |  |                                | 8 23 19 68  |  | 2:00     |                          |  |          |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN.  |          | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |  |
| White   |  | Male    |  | 6/2/1921         |  | 43 YRS.  |  |                                |   |  |          | August 23 19 68          |  | 2:00     |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                | 9. COUNTY OF DEATH  |  |          |                          |  |          |  |
| Phila. Pa.  |  |         | USA  |                  |  |  |  |                                | Balto.  |  |          |                          |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |                          |  |          |  |
| Sparrows Point<br>Balto.  |  |         |  |                  |  | Artist   |  |                                |   |  |          |                          |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         | 13b. CITY OR TOWN  |                  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                | 13d. STREET AND NUMBER  |  |          |                          |  |          |  |
| New Jersey  |  |         | Collingswood   |                  |  |  |  |                                | Parkview Apts.  |  |          |                          |  |          |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |                  |  |  |  |                                |   |  |          |                          |  |          |  |
| Frank E. Huet Sr.   |  |         | Eda  |                  |  |  |  |                                |   |  |          |                          |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         | 16b. SOCIAL SECURITY NO.   |                  |  | 17. INFORMANT  |  |                                | ADDRESS   |  |          |                          |  |          |  |
| Yes   |  |         | WW2 1943-1945- 168 12  |                  |  | 1131 William Huet  |  |                                | 506 Portland Dr<br>Broomall Pa.                                     |  |          |                          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |         |  |                  |  |  |  |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |          |                          |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |                  |  |  |  |                                |   | 4221   |          |                          |  |          |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                  |  | 20. AUTOPSY?   |  |                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |                          |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                    |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                                |   |  |          |                          |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                                |   |  |          |                          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |         |  |                  |  |  |  |                                |   | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> |          |                          |  |          |  |
| ACTUAL SIGNATURE  |  |         | M.D.   |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |                                | 22b. DATE SIGNED  |  |          |                          |  |          |  |
| EXAMINER'S NAME (Type)  |  |         | Ronald N. Kornblum, M.D.   |                  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |                                | August 23, 1968   |  |          |                          |  |          |  |
|   |  |         |  |                  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |                                | ADDRESS (Street, city, town, or county)                             |  |          |                          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                                | 23d. LOCATION (City or Town) (County) (State)                       |  |          |                          |  |          |  |
| Burial  |  |         | 8/28/1968  |                  |  | Arlington Cem.   |  |                                | Drexel Hill Del Pa  |  |          |                          |  |          |  |
| 24. FUNERAL DIRECTOR  |  |         | ADDRESS  |                  |  | 25a. REC'D BY REGISTRAR  |  |                                | 25b. SIGNATURE  |  |          |                          |  |          |  |
| Thomas Fisher; Baltimore; Md.   |  |         |  |                  |  | AUG 28 1968  |  |                                | John J. Judge   |  |          |                          |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11134

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11142

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |                               |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|-------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>JOHN   |  |  | First<br>H. JACKSON  |  |  | 2a. DATE OF DEATH<br>Month 8 Day 10 Year 1968   |  |  | 2b. HOUR<br>5:20a M   |  |  |  |  |                               |  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Negro   |  |  | 5. DATE OF BIRTH<br>Feb. 26, 1913   |  |  | 6. AGE (In years last birthday)<br>55 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                 |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Baltimore Medical Center |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Porter   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Country Club   |  |  |  |  |                               |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Monkton  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>Box 251A Troyer Road |  |                               |  |  |  |
| 14. FATHER'S NAME<br>Lewis Jackson  |  |  | First Middle Lost  |  |  | 15. MOTHER'S MAIDEN NAME<br>Margaret Britton  |  |  | First Middle Lost   |  |  |  |  |                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (no, or unknown) No  |  |  | (If yes give war or dates of service)<br>---   |  |  | 16b. SOCIAL SECURITY NO.<br>212-32-4073   |  |  | 17. INFORMANT<br>Mrs. Celia A. Jackson  |  |  | Address Troyer Road Monkton, Md. 21111         |  |                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac fibrillation</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial infarctions, old</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic cardiovascular heart disease</u> |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                               |  |  |  |
|   |  |  |  |  |  |   |  |  |   |  |  |  |  |                               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>4201</u>  |  |  |  |  |  |   |  |  |   |  |  |  |  |                               |  |  |  |
| 19a. DATE OF OPERATION<br>8/9/68  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Embolus at aortic bifurcation                                |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes                     |  |  |  |  |                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |  |  |                               |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/9, 1968</u> , to <u>8/10, 1968</u> , that (I) (we) last saw the deceased alive on <u>8/10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |  |  |                               |  |  |  |
| 22b. SIGNATURE<br><i>Rudiger Breitenecker</i>   |  |  | DEGREE<br>Attending Phys.  |  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  | 22c. DATE SIGNED<br>8/10/68   |  |  |  |  |                               |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Rudiger Breitenecker, M. D.   |  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center   |  |  |   |  |  |   |  |  |  |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>8/13/1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>West Liberty  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Fallston, Harford, Md.                         |  |  |  |  |                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>Charles E. Kurtz  |  |  | ADDRESS<br>Jarrettsville, Md.  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 13 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles E. Kurtz</i>   |  |  |  |  |                               |  |  |  |

11114

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
30M REV. 1-68

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 11135  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                           |   |   |  | 11143  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Paul R. Jenkins</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>August</i> , Day <i>26</i> , Year <i>1968</i> : <i>30</i> P. M. |   |  | 2b. HOUR   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>January 15, 1907</i>   |  | 6. AGE (In years last birthday)<br><i>61</i> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Essex</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>340 Miles Road</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Foreman</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Beth Steel</i>                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Essex</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First <i>Warren V. Jenkins</i>   |  | 15. MOTHER'S MAIDEN NAME First <i>Nellie</i> Middle <i>---</i> Last <i>---</i>                        |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>213 07 4713</i>  |   | 17. INFORMANT Address<br><i>Anna M. Jenkins 340 Miles Road</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>185X Congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Ca. prostate</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>2 yrs</i>  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs</i>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>177X</i>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                     |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>63</i> , to <i>Aug 26</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Aug 26</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Louis Semenov</i>   |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><i>8/27/68</i>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>LOUIS SEMENOFF</i>  |  |   |   | 22e. ADDRESS<br><i>2108 OREMS RD BALTO MD 21220</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>8-29-68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore Maryland</i>                   |  |
| 24. FUNERAL DIRECTOR<br><i>Aug 28 1211 Chesaco Avenue</i>  |  |   |   | 25a. REC'D BY REGISTRAR<br><i>Aug 28 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11136

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11144

|  |  |  |  |  |  |   |  |  |                        |  |  |
|--|--|--|--|--|--|---|--|--|------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MAURICE HOPE JOHNSON</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>15</b> Year <b>68</b>                           |  |  | 2b. HOUR<br><b>1:10</b> <b>am</b>   |  |  |                        |  |  |
| 3. SEX<br><b>M.</b>  |  | 4. RACE<br><b>Colored</b>  |  | 5. DATE OF BIRTH<br><b>May 29, 1920</b>  |  | 6. AGE (In years last birthday)<br><b>48</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS <b>4</b> DAYS <b>15</b>  |                        | 8. UNDER 24 HRS.<br>HOURS <b>1</b> MIN <b>10</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)<br><b>GREATER BALTO., MED. CEN.</b> |  | 12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <b>MD</b>  |  | 13b. COUNTY <b>13W</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>2007 Westwood Ave</b> |                        |  |  |
| 14. FATHER'S NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b> |  |  |   |  |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>225-20-8766</b>   |  |  | 17. INFORMANT<br><b>Dorothy Watson</b>  |  |  | Address<br><b>Same</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>POSSIBLY CEREBRAL METASTATIC CARCINOMA</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>LUNG CARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>163x</b>   |  |  |  |  |  |   |  |  |                        |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                            |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)      |   |  |  |                        |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                 |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |  |                        |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/8</b> , 19 <b>68</b> , to <b>8/15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |                        |  |  |
| 22b. SIGNATURE<br><b>Dr. Faranar Naeim</b>   |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/15/68</b>                 |                        |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>FARAMARZ NAEIM</b>   |  |  |  |  |  | 22e. ADDRESS  |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>8-18-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Abertus Mem. Ph.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>   |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR<br><b>Winston S. Phillips</b>   |  | ADDRESS<br><b>1727 N. Mount</b>  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 19 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles J. Jr.</b>  |  |  |                        |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-----------------------------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>DAVID</b>  |  |  | Middle<br><b>JONES</b>  |  |  | Last<br><b>JONES</b>  |  |  | 2a. DATE OF DEATH<br>Month<br><b>August</b> Day<br><b>14</b> Year<br><b>1968</b> |  |  | 2b. HOUR<br><b>10:15 PM</b> |  |  |
| 3. SEX<br><b>male</b>  |  |  | 4. RACE<br><b>white</b>  |  |  | 5. DATE OF BIRTH<br><b>10-6-1884</b>  |  |  | 6. AGE (In years<br>lost birthday)<br><b>83</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  | IF UNDER 24 HRS.            |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>So. Wales</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  | Md.  |  |  |                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>retired coal miner</b>                                     |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Coal Mines</b>                                       |  |  |  |  |  |                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto</b>  |  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>RD #2 - Box 353</b>                                 |  |  |                             |  |  |
| 14. FATHER'S NAME<br><b>Evan Jones</b>   |  |  | First<br><b>Jones</b>  |  |  | Middle<br><b>Jones</b>  |  |  | Last<br><b>Jones</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Martina Kittrel</b>                               |  |  | First<br><b>Kittrel</b>     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>175-16-8064</b>   |  |  | 17. INFORMANT<br><b>Family records</b>  |  |  | Address   |  |  |  |  |  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                  |  |  |                             |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b>  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |  |                             |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                             |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-14-68</b> , 19____, to <b>8-14-68</b> , 19____, that (I) (we) last<br>saw the deceased alive on <b>8-14-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                             |  |  |
| 22b. SIGNATURE<br><b>Teodoro Paglinawan, Jr., MD</b>   |  |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                               |  |  | 22c. DATE SIGNED  |  |  |  |  |  |                             |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  | <b>Teodoro Paglinawan, Jr., Md.</b>  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>  |  |  |   |  |  |  |  |  |                             |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  | 23b. DATE<br><b>Aug. 17, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Catholic Cem.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hydes, Balto. Co., Md.</b>                  |  |  |  |  |  |                             |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Md.</b>   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 21 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |                             |  |  |

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DAVID JONES

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Mr. Tolson

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Special Agent in Charge, Federal Bureau of Investigation

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*Handwritten signature*

7050 York Rd., Baltimore, Md. 21206



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*E. R. Mogela*

MEDICAL CERTIFICATION

23

VR A15 (4)  
30M REV. 1/68

11146

|   |  |  |  |  |  |  |  |                        |  |  |  |
|---|--|--|--|--|--|--|--|------------------------|--|--|--|
| 1. DECEASED NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 20. DATE OF DEATH      |  | 2b. HOUR                                     |  |
| MARY  |  | ERNESTINE  |  | KALTER   |  |  |  | Month 8 Day 10 Year 68 |  | 12:00 AM                                     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | 7. YRS.                |  | 8. IF UNDER 1 YEAR MONTHS DAYS               |  |
| FEMALE  |  | WHITE  |  | 3/20/1881  |  | 87   |  |                        |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |  |  |  |
| BALTIMORE, MD.  |  | U.S.A.   |  |  |  | Baltimore County   |  |                        |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |  |  |
| Mt. Wilson  |  | Mt. Wilson State Hospital  |  | HOUSE WIFE   |  |  |  |                        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |  |  |
| MARYLAND  |  | BALTIMORE  |  | Baltimore  |  |  |  | 410 S. PULASKI ST.     |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |                        |  |  |  |
| JOHN NICHOLSON  |  | ELEANOR RIDGEWAY   |  |  |  |  |  |                        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |                        |  |  |  |
| NO  |  |  |  | Records, Mount Wilson State Hospital   |  |  |  |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OBSTRUCTIVE AIRWAY DISEASE 011.0 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY TUBERCULOSIS, MINIMAL DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 0021   |  |  |  |  |  |  |  |                        |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)  |  |  |  |                        |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                        |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1968, to 8/10, 1968, that (I) (we) last saw the deceased alive on 8/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |                        |  |  |  |
| 22b. SIGNATURE William Newcomer   |  | 22c. DATE SIGNED 8-10-68   |  | 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.  |  | 22e. ADDRESS Mount Wilson, Maryland  |  |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE 8/14/68  |  | 23c. NAME OF CEMETERY OR CREMATORY Western Cem   |  | 23d. LOCATION (City or Town) (County) (State) Balt. Md.                                      |  |                        |  |  |  |
| 24. FUNERAL DIRECTOR The Walters Funeral Home   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                        |  |  |  |
|   |  | ADDRESS  |  | DATE AUG 15 1968   |  |  |  |                        |  |  |  |

|                |          |
|----------------|----------|
| NAME           | WHITE    |
| AGE            | 22       |
| SEX            | MALE     |
| DATE OF BIRTH  | 1892     |
| DATE OF DEATH  | 1914     |
| PLACE OF BIRTH | NEW YORK |
| PLACE OF DEATH | NEW YORK |
| Cause of Death | ...      |
| Signature      | ...      |
| Witness        | ...      |
| Registrar      | ...      |
| Official Seal  | ...      |

1112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please separate carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

|   |                              |  |  |   |                                 |  |  |
|---|------------------------------|--|--|---|---------------------------------|--|--|
| 11138   |                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                                 | 11147  |  |
| CERTIFICATE OF DEATH  |                              |  |  |   |                                 |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle   | Lost  | 20. DATE OF DEATH               |  | 2b. HOUR                                     |
| ONA   |                              |  |  | KARALIUS  | Month 8 Day 20 Year 1968        |  | M  |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday) |  | IF UNDER 1 YEAR                              |
| Female  | White                        |  | Feb 2 1880   |   | 88 YRS.                         |  | MONTHS DAYS HOURS MIN                        |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH              |  | Md.  |
| Lithuania   | US                           |  | Balto  |   |                                 |  |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Reisterstown Md   |                              | Bent N. Home   |  | UNKNOWN   |                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland  |                              | Balto  |  | City Md   |                                 | 13e. STREET AND NUMBER   |  |
|   |                              |  |  |   |                                 | 1337 Glyndon Avenue  |  |
| 14. FATHER'S NAME   |                              | First  | Middle   | Lost  | 15. MOTHER'S MAIDEN NAME        |  | First Middle Lost                            |
| Bubnis  |                              |  |  |   | Unknown                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |                                 | Address  |  |
| Unknown   |                              | 215-09-7593  |  | Albert Karalius   |                                 | 4405 Ryer Rd   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |  |  |   |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |                              |  |  |   |                                 |  |  |
| IMMEDIATE CAUSE (a) Terminal Pneumonia  |                              |  |  |   |                                 |  | 4-8 hrs                                      |
| DUE TO, OR AS A CONSEQUENCE OF  |                              |  |  |   |                                 |  |  |
| (b) Arteriosclerotic CV. Disease  |                              |  |  |   |                                 |  | years  |
| DUE TO, OR AS A CONSEQUENCE OF  |                              |  |  |   |                                 |  |  |
| (c)   |                              |  |  |   |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                              |  |  |   |                                 |  |  |
| 4221  |                              |  |  |   |                                 |  |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|   |                              |  |  |   |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                 |  |  |
|   |                              |  |  |   |                                 |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |  |  |
|   |                              |  |  |   |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19, 1968, to 8/20, 1968, that (I) (we) last saw the deceased alive on 8/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |  |   |                                 |  |  |
| 22b. SIGNATURE  |                              | 22c. DATE SIGNED   |  |   |                                 |  |  |
| Martin E. Strobel, M.D.   |                              | 8/20/68  |  |   |                                 |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |                              | 22e. ADDRESS   |  |   |                                 |  |  |
| MARTIN E. STROBEL   |                              | 59 HANOVER RD., REISTERSTOWN, MD.  |  |   |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)  |  |
| BURIAL  |                              | 8-23-1968  |  | New Cathedral Cemetery  |                                 | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR  |                              | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |                                 | 25b. REGISTRAR'S SIGNATURE   |  |
| Howard H. Hubbard   |                              | 4107 Wilkens Ave.  |  | DATE AUG 22 1968  |                                 | J. Charles Judge   |  |

Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. [illegible]".

Handwritten notes in the middle section of the page, including a signature that appears to be "J. H. [illegible]".

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "J. H. [illegible]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |  |                             |  |
|---|--|--|--|---|---|--|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |                             |  |
| 11140 CERTIFICATE OF DEATH 11148  |  |  |  |   |   |  |  |                             |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH  |  |                             | 2b. HOUR                                     |
| Helen   |  |  | Kearns   |   |   | Month Day Year<br>August 5, 1968   |  |                             | 2:30 p. M.                                   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS |  |
| female  |  | white  |  | July 11, 1900   |   | 68 YRS.  |  |                             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                             |  |
| Md.   |  | U. S.  |  |   |   | Baltimore Md.  |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Catonsville   |  |  | SPRING GROVE STATE HOSPITAL  |   |   | housewife  |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER      |  |
| Md.   |  |  |  |   | Balto   |  |  | 4707 Pennington Avenue      |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |  |  |                             |  |
| First Middle Last   |  |  | First Middle Last  |   |   |  |  |                             |  |
| John  |  |  | BAUMGARTNER  |   |   | Anna Leonard   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |  |                             |  |
| No  |  |  | 213-30-9557  |   | Address<br>Records: SPRING GROVE STATE HOSPITAL                     |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, massive,</u>   |  |  |  |   |   |  |  |                             | 10 min.                                      |
| 453x DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pelvic vein thrombosis, suspected.</u>  |  |  |  |   |   |  |  |                             | 1 wk.  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 456x<br>(c) <u>disease (10 yrs)</u>  |  |  |  |   |   |  |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |  |  |                             | 10 yrs                                       |
| 1) Left Carotid artery thrombosis (June '68), 2) Arteriosclerotic card-   |  |  |  |   |   |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |  |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |   |  |  |                             |  |
|   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |  |  |                             |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | City or Town   |  | County                      | State  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  | Street or R.F.D. No.  |   |  |  |                             |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 1, 1968, to Aug. 5, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 5, 1968, and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |   |   |  |  |                             |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |   |  |  |                             |  |
|   |  | 8-5-68   |  |   |   |  |  |                             |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |   |   |  |  |                             |  |
| Anthony J. Young, M.D.  |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                     |  |   |   |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)   |  | (County)                    | (State)                                      |
| BURIAL  |  | 8/8/68   |  | GLEN HAVEN  |   | BALTO.   |  | MD.                         |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |  |                             |  |
| J.G. CONNELLY SONS  |  | 300 MACE   |  | DATE AUG 8 1968   |   | Charles Judge  |  |                             |  |

11149

11148

DEPARTMENT OF HEALTH

REPORT

11149

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| 11144  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 11149   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First William Middle G. Last Keefer SP.  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>Month 8 Day 23 Year 68   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>M   |  |  |  |  |   |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>5-17-91   |  |  |  |  | 6. AGE (in years<br>last birthday)<br>77 YRS.   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN               |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Md.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto Co Gen Hosp |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Painter   |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Const. Co.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.   |  |  |  |  | 13b. COUNTY<br>—   |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>2611 Georgetown Rd.   |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Frank Keefer  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>unknown  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-03-6517  |  |  |  |  | 17. INFORMANT<br>William J. Keefer Jr. Address 263 McClellan St.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 days                                       |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4301   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG. 19, 1968, to AUG. 23, 1968, that (I) (we) last saw the deceased alive on AUG. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Fausto Q. Aquino J.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | DEGREE  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br>8/23/68                 |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Fausto Q. Aquino, Jr.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN. HOSPITAL  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>8/26/1968   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Balto. Co. Md.                       |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Vozar & Son Inc. 901 Hollins St.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 26 1968   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |  |  |  |

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11142

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11150

|   |  |   |       |   |  |   |   |  |                                |   |      |
|---|--|---|-------|---|--|---|---|--|--------------------------------|---|------|
| 1. DECEASED-NAME<br>(Type or print) <b>ANDREW</b>   |  |   | First | Middle  | Lost   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>6</b> Year <b>68</b>                                 |   |  | 2b. HOUR<br><b>12:08</b><br>AM |   |      |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>C</b>   |       | 5. DATE OF BIRTH<br><b>December 11, 1887</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>80</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS                        | OAYS                           | IF UNDER 24 HRS.<br>HOURS                       | MIN  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |   |  |                                |   |      |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>GR. BALTO., MED. CENTER</b> |       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>C&amp;P Tel. Co.</b>                                       |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |                                |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |       | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>117 Croydon Rd.</b> |                                |   |      |
| 14. FATHER'S NAME<br><b>Andrew W. Keisecome</b>   |  |   | First | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME<br><b>Emma Hensley</b>   |   |  | First                          | Middle  | Lost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |       | 17. INFORMANT<br><b>Mrs. Conrad Tamen</b>   |  | Address<br><b>Same</b>  |   |  |                                |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br><b>2509</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DIABETES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GANGRENE</b> |  |   |       |   |  |   |   |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>260x</b>   |  |   |       |   |  |   |   |  |                                |   |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |                                |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |                                |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/30</b> , 19 <b>68</b> , to <b>8/6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |   |       |   |  |   |   |  |                                |   |      |
| 22b. SIGNATURE<br><b>M.G. LAZARUS</b>   |  | DEGREE<br><b>MD.</b>  |       | ATTENDING<br>PHYS.<br><input type="checkbox"/>  |  | MED.<br>DIRECTOR<br><input type="checkbox"/>  |   | STAFF<br>PHYS.<br><input type="checkbox"/>       |                                | 22c. DATE SIGNED<br><b>AUG. 6th, 1968</b>       |      |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>M.G. LAZARUS, MD.</b>   |  | 22e. ADDRESS<br><b>G B M C</b>  |       |   |  |   |   |  |                                |   |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-8-68</b>  |       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |   |  |                                |   |      |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |  | ADDRESS<br><b>6500 York Rd.</b>   |       | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |                                |   |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11143

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11151

|  |  |  |  |   |  |  |   |   |  |   |  |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Gertrude R. Kilchenstein  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>8 16 1968           |   |  | 2b. HOUR<br>2:55M  |   |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Cau   |  | 5. DATE OF BIRTH<br>1-13-1901   |  | 6. AGE (In years<br>last birthday)<br>67 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  | IF UNDER 24 HRS.<br>HOURS MIN                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Overlea (Rual)  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>135 Lyndale Ave |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Housewife                                    |   |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Overlea  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>135 Lyndale Avenue 36 |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Joseph Schaefer  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Magdalene |   |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Mrs William DeV Vaughn   |  | Address<br>135 Lyndale Avenue 36   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lympho-sarcoma of pelvic</u><br><u>2001</u> DUE TO, OR AS A CONSEQUENCE OF <u>region &amp; metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yrs</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>2001</u>  |  |  |  |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>9-14-65</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>sarcoma</u>                                 |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                    |  |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                      |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-13-1968</u> , to <u>8-16-1968</u> , that (I) (we) last saw the deceased alive on <u>8-13-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>J. Duer Moores MD</u>   |  | 22c. DATE SIGNED<br><u>8-17-68</u>   |  | 22d. PHYSICIAN'S<br>NAME (Type) <u>J. DUER MOORES</u>   |  |  |   |   |  |   |  |
| 22e. ADDRESS<br><u>3105 BELAIR RD 21213</u>  |  |  |  |   |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>8-19-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore City Md.     |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Behair Road 21236  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 20 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>                                |   |   |  |   |  |

11154

11154

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "and" and "the" are faintly visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |         |   |                                   |   |                                |
|--|---------|---|-----------------------------------|---|--------------------------------|
| 11144  |         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |                                   | 11152   |                                |
| Items#13b&13e Film#G404 9/6/68   |         |   |                                   |   |                                |
| 1. DECEASED-NAME<br>(Type or print)  |         |   | 2a. DATE OF DEATH                 |   | 2b. HOUR                       |
| First Middle Last<br>LOUISE SOPHIE KLARNER   |         |   | August Month Day Year<br>23, 1968 |   | p. M.                          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |                                   | 6. AGE (In years<br>lost birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |
| FEMALE   | WHITE   | 11/24/76  |                                   | 91 YRS.   | HOURS MIN.                     |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |
| Berlin, Germany  |         | U.S.A.  |                                   | 9. COUNTY OF DEATH<br>Baltimore Md.   |                                |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                |
| Baltimore  |         | Augsburg Home<br>6811 Campfield Road  |                                   | Housewife   |                                |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |         | 13b. CITY OR TOWN   |                                   | 13c. INSIDE CITY LIMITS?  |                                |
| Maryland   |         | Baltimore   |                                   | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |
| 14. FATHER'S NAME First Middle Last  |         | 15. MOTHER'S MAIDEN NAME First Middle Last                                      |                                   | 13e. STREET AND NUMBER  |                                |
| William F. Serbe   |         | Louisa Malke  |                                   | 21212   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT   |                                |
| No   |         | 216-54-2018   |                                   | Secretary at Augsburg Home<br>Anita W. Strohmer 2127 Old Frederick Rd   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |                                   |   |                                |
| PART I. DEATH WAS CAUSED BY:   |         |   |                                   |   |                                |
| IMMEDIATE CAUSE (a) <u>Repeated Strokes</u>  |         |   |                                   |   |                                |
| 4379 DUE TO, OR AS A CONSEQUENCE OF  |         |   |                                   |   |                                |
| (b) <u>Cerebral Arteriosclerosis</u>   |         |   |                                   |   |                                |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                                   |   |                                |
| (c) <u>and Senility</u>  |         |   |                                   |   |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |   |                                   |   |                                |
| 334 X  |         |   |                                   |   |                                |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                   | 20a. AUTOPSY?   |                                |
|  |         |   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 20, 1968</u> to <u>Aug 22, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>Aug 22, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |         |   |                                   |   |                                |
| 22b. SIGNATURE   |         | DEGREE  |                                   | 22c. DATE SIGNED  |                                |
| <u>Dr. Paul Byerly</u>   |         |   |                                   | <u>8/26/68</u>  |                                |
| 22d. PHYSICIAN'S<br>NAME (Type)  |         | 22e. ADDRESS  |                                   |   |                                |
| <u>Dr. Paul Byerly</u>   |         | <u>5820 York Rd Balto 21212</u>   |                                   |   |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |                                   | 23c. NAME OF CEMETERY OR CREMATORY  |                                |
| <u>Burial Aug 28 1968</u>  |         |   |                                   | <u>Burial Ridge Balto</u>   |                                |
| 24. FUNERAL DIRECTOR   |         | ADDRESS   |                                   | 25a. REC'D BY REGISTRAR   |                                |
| <u>U. Heermann</u>   |         | <u>6067 Hay Rd</u>  |                                   | DATE SEP 3 1968   |                                |
|  |         |   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                |

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2011

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## ANSWER

1995

## FINAL

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**Abstract**

STANDARD FORM NO. 64

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|-----------------------------|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 11145  |  |  |  |   |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |   |  |  |  |                             |  |  |  | 11153                  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>HELEN A KLINEFEITER  |  |  |  |   |  |  |  |   |  |  |  | 2a. DATE OF DEATH Month Day Year<br>August 9 1968  |  |  |  |   |  |  |  |                             |  |  |  | 2b. HOUR<br>12:00 P.M. |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  | 4. RACE<br>White  |  |  |  | 5. DATE OF BIRTH<br>JUNE 6, 1914  |  |  |  | 6. AGE (In years lost birthday)<br>54 YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                   |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Chesapeake Manor<br>509 E. Joppa Road |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  |  | 13b. COUNTY<br>-  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br>1019 W. 37th Street |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Harold L HETRICK  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>EISIE Conkey  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT Address   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 153.9 Melastatic Carcinoma of Lung - Sukes<br>DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Breast<br>DUE TO, OR AS A CONSEQUENCE OF (c) 2 yrs<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>153.9  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/8/68, 1968, to 8/13/68, 1968, that (I) (we) last saw the deceased alive on 8/8/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles F. O'Donnell   |  |  |  | 22c. DATE SIGNED<br>8/13/68   |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Charles F. O'Donnell M.D.   |  |  |  | 22e. ADDRESS<br>7501 York Road TOWSON  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  | 23b. DATE<br>Aug 12, 1968   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>EVERGREEN Mem Gardens   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Finksburg Carroll Co. Md                    |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Brynce Funeral Home Bldg. Md   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 13 1968   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11146

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11154

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Bernard W. Kohlenstein</i>   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><i>Aug 18 1968</i>         |   |  | 2b. HOUR<br><i>2:55 A M</i>   |  |  |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>WHITE</i>   |   | 5. DATE OF BIRTH<br><i>Sept 18, 1912</i>  |  | 6. AGE (in years lost birthday)<br><i>55</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Balto County</i> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Garrison, Md.</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Fox Leugh NURSING HOME</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>SALESMAN</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>WHOLESALE</i>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MARYLAND</i>  |  | 13b. COUNTY<br><i>BALTIMORE</i>   |   | 13c. CITY OR TOWN<br><i>RANDALLSTOWN</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>9004 ALLENSWOOD ROAD</i>            |  |
| 14. FATHER'S NAME First Middle Last<br><i>Louis Kohlenstein</i>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Hannah Weiss</i> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, at unknown<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>213-40-5591</i>  |   | 17. INFORMANT<br><i>MRS. LEANORE KOHLENSTEIN</i>  |  | Address<br><i>9004 ALLENSWOOD ROAD #21133</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Glioblastoma Multiforme</i><br><i>1729</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 months</i> |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>1939</i>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-11</i> , 19 <i>68</i> , to <i>8-18</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>8-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>David F. Miller</i>  |  |   |   | DEGREE ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><i>8-18-68</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>David F. Miller</i>  |  |   |   | 22e. ADDRESS<br><i>9115 Reisterstown Rd. Owings Mills, Md.</i>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>8-19-68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BALTIMORE HEBREW</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>BALTIMORE, MARYLAND</i>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>AUG 20 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>John  |  |  | Middle<br>A.  |  |  | Last<br>Kramer  |  |  | 2a. DATE OF DEATH<br>Month<br>August<br>Day<br>23<br>Year<br>68 |  |  | 2b. HOUR<br>9.35 AM               |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>4-29-1890   |  |  | 6. AGE (In years<br>last birthday)<br>78 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.              |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Ret. Mail clerk   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Black & Deck  |  |  |   |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Parkville  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>7424 Brookwood Ave., 21236            |  |  |                                   |  |  |
| 14. FATHER'S NAME<br>First<br>Conrad  |  |  | Middle<br>Kramer   |  |  | Last<br>Kramer  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Mary   |  |  | Middle<br>Taylor  |  |  | Last<br>Taylor                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>212-10-9831A  |  |  | 17. INFORMANT<br>Address<br>Mr Charles Miller 6212 Brook Avenue 6                               |  |  |   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>Senility</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>491X |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/16/1968</u> , to <u>8/23/1968</u> , that (I) (we) last<br>saw the deceased alive on <u>8/23/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><i>Christine Feliciano, M.D.</i>  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br>8/24/68   |  |  |   |  |  |                                   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Christine Feliciano, M. D.   |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>8-27-1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co Md                                |  |  |   |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home  |  |  | ADDRESS<br>7401 Belair Road 21236  |  |  | 25a. REC'D. BY REGISTRAR<br>DATE<br>AUG 27 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Judge</i>  |  |  |   |  |  |                                   |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11148

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11156

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>KEITH EDWARD KRAUSE</b>   |  |  | 2a. DATE OF DEATH<br>8 Month 12 Day 68 Year                       |   |  | 2b. HOUR<br>1:40 PM   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cau.  |   | 5. DATE OF BIRTH<br>8/4/68  |  | 6. AGE (In years last birthday)<br>8 days YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Cen. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>NONE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>NONE   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  | 13b. COUNTY Harford  |   | 13c. CITY OR TOWN Bel Air   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>17 E. Ring Factory Road     |  |
| 14. FATHER'S NAME First Middle Last<br>Charles Patrick Kraus  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Lorraine Mary Sipka |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO   |  | 16b. SOCIAL SECURITY NO.<br>NONE   |   | 17. INFORMANT (Father) 879-2616<br>Mr. Charles P. Kraus   |  | 17 Address<br>17 East Ring Factory Road<br>Bel Air, Maryland 21014                              |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u><br>7761 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>7735   |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/1968, to 8/12/1968, that (I) (we) last saw the deceased alive on 8/12/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Rudiger Breiteneker</i>  |  |  |   | DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br>8/12/68   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Rudiger Breiteneker, M.D.   |  |  |   | 22e. ADDRESS<br>Greater Baltimore Medical Center  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>August 14, 1968   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Memorial Gardens  |  | 23d. LOCATION (City or Town) (County) (State)<br>Bel Air Harford Co. Md. 21014                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>Foster Funeral Home   |  |  |   | ADDRESS<br>10 Broadway Williams St.<br>Bel Air, Maryland 21014  |  | 25a. REC'D BY REGISTRAR<br>AUG 15 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i> |  |

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Handwritten notes and signatures in the upper section of the document, including a signature that appears to read "J. H. [illegible]".

Handwritten notes and signatures in the middle section of the document, including a signature that appears to read "J. H. [illegible]".

Handwritten notes and signatures in the lower section of the document, including a signature that appears to read "J. H. [illegible]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2a Film G403 8/16/68

CERTIFICATE OF DEATH

|  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Margaret B. Lally</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>August 12 1968</b>    |   |  | 2b. HOUR<br>M<br><b>11157</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH<br><b>7/2/1897</b>   |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Typist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>2024 Bank St.</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Michael Lally</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Kelly</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-3395-A</b>  |   | 17. INFORMANT<br><b>Hospice Records</b>   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4221</b><br>(b) <b>Cerebral Vascular Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ABCVD</b> |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs</b><br><b>acute</b><br><b>chronic</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Prn CVA (nt)</b>  |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/29/68</b> , 19 <b>68</b> , to <b>8/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>David Wager</b>   |  |   |   | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. DAVID WAGER</b>  |  |   |   | 22e. ADDRESS<br><b>812 Mockingbird Lane 21204</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/16/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>John A. Moran, Inc. 3000 E. Baltimore St.</b>   |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 19 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be counted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |                 |   |   |   |   |  |  |
|--|--|--|-----------------|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>WALTER  | Middle<br>FRANK | Last<br>LAMKY (LAMKA)   | 2a. DATE OF DEATH<br>Month Day Year<br>AUGUST 18, 1968  |   |   | 2b. HOUR<br>8:15P M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |                 | 5. DATE OF BIRTH<br>10/12/95  |   | 6. AGE (In years<br>last birthday)<br>72 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>U.S.A. MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>VETERANS ADMIN HOSPITAL |                 |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>GUARD |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |                 | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>BOX 125 BACK RIVER NECK RD             |  |
| 14. FATHER'S NAME<br>First Middle Last<br>STEPHEN LAMKY  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>VICTORIA ULCESKI  |                 |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>YES WW I  |  | 16b. SOCIAL SECURITY NO.<br>213 07 02 72   |                 | 17. INFORMANT<br>Address<br>CLINICAL RECORDS, VAH FT HOWARD, MARYLAND   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1621 TERMINAL CA OF THE LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |                 |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
|  |  |  |                 |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>163X  |  |  |                 |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                 |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/17/68, 19__, to 8/18/68, 19__, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on 8/18/68, 19__, and that in <input checked="" type="checkbox"/> (my/our) opinion death occurred on the date and hour and from the<br>causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |                 |   |   |   |   |  |  |
| 22b. SIGNATURE<br>[Signature]  |  |  |                 | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>             |   | 22c. DATE SIGNED<br>8/19/68   |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>CELIAR E. PARRA, M.D.   |  |  |                 | 22e. ADDRESS<br>VA HOSPITAL, FORT HOWARD, MARYLAND  |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>8/21/68   |                 | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY   |   | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>CONNELLY FUNERAL HOME, MACE AVE, BALTO, MD  |  |  |                 | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 21 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>111152</span> <span>CERTIFICATE OF DEATH</span> <span>111159</span> </div>   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First <b>Donald</b> Middle <b>Marsden</b> Last <b>LaMon</b>  |  |  |  |  |  | 2a. DATE OF DEATH Month <b>Aug</b> Day <b>17</b> Year <b>68</b>                   |  | 2b. HOUR <b>7:30 AM</b>   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>JULY 24 1926</b>   |  | 6. AGE (In years last birthday) <b>42</b> YRS.                                    |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore County</b> Md.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Rockdale</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3415 Meadow Dale Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Management Analyst</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Sol. Sec.</b>                                |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Rockdale</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>3415 Meadow Dale Rd. 21133</b>                                |  |
| 14. FATHER'S NAME First <b>Robert Lee</b> Middle <b>LaMon</b> Last <b></b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>DRAKE</b> Last <b></b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war or dates of service) <b>1944-1945</b>  |  | 16b. SOCIAL SECURITY NO. <b>135-22-9739</b>  |  | 17. INFORMANT Address <b>Mrs. Donald LaMon</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109</b> <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>A.S.H.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF <b></b><br>(c) <b></b> |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>2 yrs.</b>         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b> <b>None</b>   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>              |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> 19 <b>68</b> , to <b>present</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>8/16</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Bernard Burgan M.D.</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED <b>8/17/68</b>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Bernard Burgan M.D.</b>   |  |  |  | 22e. ADDRESS <b>3809 Clark Lane Balto. 15</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |  | 23b. DATE <b>Aug. 17, 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Protestant Cemetery</b>  |  | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b></b> (State) <b>Md.</b> |  | 23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers</b> ADDRESS <b>8728 Liberty Road Randallstown</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>AUG 19 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                   |  |   |  |

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## CERTIFICATE OF DEATH

|   |         |                              |  |  |                                    |   |  |  |                                   |  |
|---|---------|------------------------------|--|--|------------------------------------|---|--|--|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |         |                              | First  | Middle   | Last                               | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR                          |  |
| Ernest Frederick Lang   |         |                              |  |  |                                    | August 19, 1968   |  |  | 2:30 P.M.                         |  |
| 3. SEX  | 4. RACE |                              | 5. DATE OF BIRTH   |  |                                    | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |
| M   | W       |                              | 4/15/1891  |  |                                    | 77 YRS.   |  | MONTHS DAYS  |                                   | HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  |  |                                   |  |
| Md.   |         | U.S.A.                       |  |  |                                    | Baltimore Md.   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore 12  |         |                              | 138 Brandon Rd.  |  |                                    | Lithographer Amer. Bank Stat.   |  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |
| Md.   |         |                              | Baltimore  |  | Balto. 12                          |   |  |  | 500 Sunwood Court                 |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |  |  |                                   |  |
| John David Lang   |         |                              | Mary Waltgan   |  |                                    |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                      |   |  | Address  |                                   |  |
| No  |         |                              | 215-09-0201  |  | Mrs. Donald Wright                 |   |  | 21212 Melrose Ave  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                              |  |  |                                    |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |         |                              |  |  |                                    |   |  |  |                                   |  |
| IMMEDIATE CAUSE (a) <u>Acute gastro-intestinal hemorrhage</u>   |         |                              |  |  |                                    |   |  |  |                                   | 48 hrs                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |                                    |   |  |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5430</u>  |         |                              |  |  |                                    |   |  |  |                                   | 5 days                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |                                    |   |  |  |                                   |  |
| (c)   |         |                              |  |  |                                    |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                              |  |  |                                    |   |  |  |                                   |  |
| <u>Generalized arteriosclerosis &amp; hemiparesis &amp; aphasia</u>   |         |                              |  |  |                                    |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |         |                              |  |  |                                    |   |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                   |  |
|   |         |                              |  |  |                                    |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                                   |  |
|   |         |                              |  |  |                                    |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1968</u> , to <u>Aug 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |                              |  |  |                                    |   |  |  |                                   |  |
| 22b. SIGNATURE<br><u>Frederick J. Vollmer M.D.</u>  |         |                              |  |  |                                    | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>Aug 20, 1968</u>                              |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Dr. Frederick J. Vollmer</u>   |         |                              |  |  |                                    | 22e. ADDRESS<br><u>6100 York Road</u>   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State)                        |                                   |  |
| Burial  |         |                              | 8/22/68  |  | Parkwood                           |   |  | Parkville, Balto. Co., Md.   |                                   |  |
| 24. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co.</u>  |         |                              |  |  |                                    | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| 4905 York Rd.<br>Balto. 12, Md.   |         |                              |  |  |                                    | DATE<br><u>AUG 22 1968</u>  |  | <u>Charles Judge</u>   |                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 11153  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 11161   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>FRONIA A. LAWRENCE   |  |  | 2a. DATE OF DEATH<br>AUG Month 23 Day 1968 Year |   |  | 2b. HOUR<br>510 P M   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>APR 7, 1888   |  | 6. AGE (In years lost birthday)<br>80 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>GA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTO.  |  |
| 10. CITY OR TOWN OF DEATH<br>ESSEX   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>116 STEAMERS RUN RD                |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD   |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>ESSEX  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>116 STEAMERS RUN RD  |  | 14. FATHER'S NAME First Middle Last<br>PADGETT   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>SALLIE KENT   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO   |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)   |   | 17. INFORMANT<br>MAE JONES  |  | Address<br>ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA<br>2000 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2000 |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 MO.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>ARTERIO SCLEROTIC HEART DISEASE  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 5, 1967, to AUG 23, 1968, that (I) (we) last saw the deceased alive on AUG 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>Joseph Miceli MD   |  |  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>8/26/68   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>JOSEPH MICELI M.D.   |  |  |   | 22e. ADDRESS<br>108 S. TAYLOR AVE, ESSEX, MD. 21221   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>8/26/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO. MD.                                     |  |
| 24. FUNERAL DIRECTOR<br>J.G. CONNELLY SONS   |  |  |   | ADDRESS<br>300 MACE   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 28 1968   |  |
|  |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |   |  |
| 11154   |  |  |  |   |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First Samuel   |  | Middle NMI  |  | Last Levin  |  | 2a. DATE OF DEATH<br>08 Month 2 Day Year 68                             |  | 2b. HOUR<br>12:05 PM                                      |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>6/1/05  |  | 6. AGE (In years<br>last birthday)<br>63 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN                             |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Balto   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Balto.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Baltimore County Gen. |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Ins Agent   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Supervisor  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2 Amleht Ct.                                  |  |   |  |
| 14. FATHER'S NAME<br>First Joseph   |  | Middle NMI   |  | Last Levin  |  | 15. MOTHER'S MAIDEN NAME<br>First Sophia  |  | Middle Weinberg   |  | Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Fannie Levin  |  | Address<br>#2 Amleht Court 21215  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY;<br>OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION<br>Street or R.F.D. No.   |  | City or Town  |  | County  |  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUG. 20</u> , 19 <u>68</u> , to <u>AUG. 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>AUG. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Fausto Q. Aquino Jr   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/>                                  |  | STAFF PHYS. <input type="checkbox"/>                      |  |
| 22b. PHYSICIAN'S NAME (Type)<br>FAUSTO Q. AQUINO, JR  |  |  |  |   |  | 22c. DATE SIGNED<br>8/24/68   |  |   |  |   |  |
| 22b. ADDRESS<br>c/o BALTO. COUNTY GEN. HOSP.  |  |  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8/25/1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hebrew Young Men  |  | 23d. LOCATION (City or Town)<br>Baltimore,  |  | (County)<br>Maryland  |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br>Sol Levinson & Bros. 6010 Reisterstown Road   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 27 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |  |   |  |

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "TABLE" and "CHAPTER" are faintly visible.]*

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11155

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11163

|   |  |  |                          |   |   |  |                              |
|---|--|--|--------------------------|---|---|--|------------------------------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Mary</b>  |  | First<br><b>Mary</b>   | Middle<br><b>Theresa</b> | Last<br><b>LOFTUS</b>   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>5</b> Year <b>68</b> |  | 2b. HOUR<br><b>3:50 P.M.</b> |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |                          | 5. DATE OF BIRTH<br><b>7-3-54</b>   |   | 6. AGE (In years lost birthday)<br><b>14</b> YRS.  |                              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                          | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |                              |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hospital</b> |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dependent</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |                          | 13c. CITY OR TOWN<br><b>Rockville</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |
| 13e. STREET AND NUMBER<br><b>13720 Lionel Lane</b>  |  | 14. FATHER'S NAME First<br><b>Joseph</b>   |                          | Middle<br><b>John</b>   |   | Last<br><b>Loftus</b>  |                              |
| 15. MOTHER'S MAIDEN NAME First<br><b>Adeline</b>  |  | Middle<br><b>Miele</b>   |                          | Last<br><b>Loftus</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) |                              |
| 16b. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT<br><b>Rosewood's Records</b>   |                          | Address<br><b>Owings Mills, Maryland</b>  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electrolytes imbalance</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>486X</b><br>(b) <b>Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b>        |  |  |                          |   |   |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>Chronic Brain Syndrome Mongolism severe mental deficiency</b>  |  |  |                          |   |   |  |                              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                              |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>7/3</b> , 19 <b>54</b> , to <b>8/5</b> , 19 <b>68</b> , that <del>it</del> (we) last saw the deceased alive on <b>8/5</b> , 19 <b>68</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) did <del>not</del> view the body after death. |  |  |                          |   |   |  |                              |
| 22b. SIGNATURE<br><b>Esteban V. Diaz M.D.</b>   |  | DEGREE<br><b>M.D.</b>  |                          | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |   | 22c. DATE SIGNED<br><b>8-8-68</b>  |                              |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ESTEBAN V. DIAZ M.D.</b>   |  | 22e. ADDRESS<br><b>321-E-BELCREST-Rd. BEL-AIR, Md.</b>   |                          |   |   |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 9, 68</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosewood Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Owings Mills, Md.</b>  |                              |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons</b>   |  |  |                          | ADDRESS<br><b>Reisterstown, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 12 1968</b>   |                              |
|   |  |  |                          | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
|---|--|--|--|--|------------------------------------|--|---|--|--|------------------------|-----------------|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 11156   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 11164   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |                                    | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |                        |                 |                                   |  |  |
| BERTHA HELENE LOWENSTEIN  |  |  |  |  |                                    | Month 8 Day 19 Year 68   |   |  | 1:20 PM  |                        |                 |                                   |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                    |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |                        | IF UNDER 1 YRS. |                                   |  |  |
| F.  |  | W  |  | August 27, 1885  |                                    |  | 82 YRS.   |  | MONTHS   |                        | DAYS            |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?                         |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH   |                        |                 | Md.                               |  |  |
| Maryland  |  |  | U.S.A.   |  |                                    |  |   |  | BALTIMORE  |                        |                 |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                        |                 | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTIMORE, MD.  |  |  |  | GREATER BALTO. MED. CEN.   |                                    |  |   | Floor Lady   |  |                        |                 | Aetna Shirt Co.                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |                 |                                   |  |  |
| Maryland  |  |  |  | Baltimore  |                                    | Baltimore  |   |  |  | 1530 Upshire Road,     |                 |                                   |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  |                                    | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |  |                        |                 |                                   |  |  |
| Herklutz (late)   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT Address  |   |  |  |                        |                 |                                   |  |  |
|   |  |  |  |  |                                    | Walter Herklutz, 5538 Caswell Road, 21207  |   |  |  |                        |                 |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION  |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 1 week.  |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) (c)   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 4201  |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED     |  |                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |                 |                                   |  |  |
|   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                        |                 |                                   |  |  |
|   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. |  | City or Town  |  | County   |                        | State           |                                   |  |  |
|   |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/18, 1968, to 8/19, 1968, that (I) (we) lost the deceased alive on 8/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |   |  |  |                        |                 |                                   |  |  |
| 22b. SIGNATURE  |  |  |  |  |                                    | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   |  | 22c. DATE SIGNED   |                        |                 |                                   |  |  |
| MCGHIE, DUNCAN  |  |  |  |  |                                    |  |   |  | 8/19/68  |                        |                 |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |                                    | 22e. ADDRESS   |   |  |  |                        |                 |                                   |  |  |
|   |  |  |  |  |                                    | 922 Woodson Rd BALTO 2 Zone 12   |   |  |  |                        |                 |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION (City or Town) (County) (State)  |  |                        |                 |                                   |  |  |
| Burial  |  |  | 8/22/68  |  | Loudon Park                        |  |   | Baltimore, Md.   |  |                        |                 |                                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                                    | 25a. REC'D BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE   |                        |                 |                                   |  |  |
| Walter 4101 Edmondson ave., 21229   |  |  |  |  |                                    | AUG 20 1968  |   |  | John Charles Judge   |                        |                 |                                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 11157   |  |   |  |   |   |  |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |  |  |
| 1. DECEASED-NAME (Type or print) <sup>First</sup> <u>MICHAEL</u> <sup>Middle</sup> <u>LEO</u> <sup>Last</sup> <u>LUCAS</u>  |  |   |  |   | 2a. DATE OF DEATH <sup>Month</sup> <u>AUGUST</u> <sup>Day</sup> <u>25</u> <sup>Year</sup> <u>1968</u> |  | 2b. HOUR <u>4:30</u> M  |  |  |
| 3. SEX <u>MALE</u>  |  | 4. RACE <u>WHITE</u>  |  | 5. DATE OF BIRTH <u>9-15-05</u>   |   | 6. AGE (In years last birthday) <u>62</u> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Md.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <u>Baltimore County</u> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH <u>Mt. Wilson</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Mt. Wilson State Hospital</u> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>FARMER</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO</u>                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>  |  | 13b. COUNTY <u>CHARLES</u>  |  | 13c. CITY OR TOWN <u>WALDORF</u>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <u>NONE</u>                               |  |
| 14. FATHER'S NAME <sup>First</sup> <u>LUTHER</u> <sup>Middle</sup> <u>LUCAS</u> <sup>Last</sup>   |  |   | 15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>MARY</u> <sup>Middle</sup> <u>JENKINS</u> <sup>Last</sup> |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WWII</u> (If yes give year or date of service)  |  |   | 16b. SOCIAL SECURITY NO. <u>218-12-9433</u>  |   | 17. INFORMANT <u>Records, Mt. Wilson State Hospital</u>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>① BRONCHOPNEUMONIA</u><br><u>1621</u> DUE TO, OR AS A CONSEQUENCE OF, <u>CHRONIC @ UPPER LOBE OF LUNG</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CHRONIC @ UPPER LOBE OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>163X</u>   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION <u>7-22-68</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3</u> , 19 <u>68</u> , to <u>AUGUST 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE <u>W Newcomer</u>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED <u>8-25-68</u>  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>  |  |   |  | 22e. ADDRESS <u>Mount Wilson, Maryland</u>  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE <u>8-29-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>ST PETERS Cem.</u>  |   | 23d. LOCATION (City or Town) (County) (State) <u>WALDORF, CHARLES, MD.</u>                   |   |  |  |
| 24. FUNERAL DIRECTOR <u>Hunt Funeral Home, Waldorf, Md</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |  |  |
|   |  |   |  | DATE <u>AUG 30 1968</u>   |   |  |   |  |  |

2002-2003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Lillian</b>   |  |  | First <b>Lillian</b> Middle <b>L</b> Last <b>LUDWIG</b>                        |   |  | 2a. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>21</b> Year <b>68</b>         |  | 2b. HOUR<br><b>8:45A</b> M                                       |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>8-1-01</b>   |  | 6. AGE (In years last birthday)<br><b>67</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTO. COUNTY GEN. H.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                         |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MD</b> COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>3459 cottage Ave</b>                           |  |  |  |
| 14. FATHER'S NAME<br>First <b>Lillian</b> Middle <b>L</b> Last <b>LUDWIG</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>REBECCA</b> Middle <b>L</b> Last <b>?</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-0658A</b>  |  | 17. INFORMANT<br>Address <b>MR. HERMAN KESSLER, 5921 SIMMONDS AVE. #15</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4109</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                            |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/21/68</b> , 19 <b>68</b> , to <b>8/21</b> , 19 <b>68</b> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <b>8/21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input checked="" type="checkbox"/> did (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gregorio Wearfon, MD</b> DEGREE   |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/21/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GREGORIO WEARFON</b>  |  |  |  | 22e. ADDRESS<br><b>BALTO. COUNTY GENERAL HOSPITAL</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-23-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>   |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 23 1968</b>                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>            |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11167

|   |                  |  |              |   |   |  |   |
|---|------------------|--|--------------|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First<br>Glen  | Middle<br>H. | Last<br>Luttrell  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/><br>Month Day Year<br>Aug. 20, 19 68 |  | 2b. HOUR<br>12:15 P.M.  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>Sept. 21, 1908   |              | 6. AGE (In years last birthday)<br>59 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.                                       | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>August 20 19 68 |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>3431 Walford Drive |              |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Police Dept. Bethlehem Steel Co.         |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |                  | 13b. COUNTY<br>Baltimore   |              | 13c. CITY OR TOWN<br>Dundalk  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     | 13e. STREET AND NUMBER<br>3431 Walford Drive                         |   |
| 14. FATHER'S NAME<br>First Middle Last<br>Samuel Lee Luttrell   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Nye  |              |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No  |  |   |
| 16b. SOCIAL SECURITY NO.<br>213-09-3345   |                  | 17. INFORMANT (Wife)<br>Mrs. Virginia Luttrell, 3431 Walford Dr.                                   |              |   | ADDRESS Dundalk, Md.  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u><br>157.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos  |                  |  |              |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>157x <u>None</u>  |                  |  |              |   |   |  |   |
| 19a. DATE OF OPERATION<br>April 29-68   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Abdominal Pain & Jaundice                      |              |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>19   |              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <u>M B Davis</u> M.D.<br>EXAMINER'S NAME (Type) Melvin B. Davis M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd.<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED August 21, 1968<br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) Dundalk, Md. 21222 |                  |  |              |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>8/23/68   |              | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland |   |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |                  |  |              | 25a. REC'D BY REGISTRAR<br>DATE AUG 23 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |   |

John A. Smith, 1922 Ave. 1, Seattle, W.

AUG 13 1968

Mr. J. Edgar Hoover, Director, FBI, Washington, D.C.

Dear Sir:

I am writing to you regarding the matter of the

investigation of the activities of the

Communist Party, U.S.A., in the

State of Washington.

I have been advised that you are

interested in the activities of the

Communist Party, U.S.A., in the

State of Washington.

I have been advised that you are

interested in the activities of the

Communist Party, U.S.A., in the

State of Washington.

I have been advised that you are

interested in the activities of the

Communist Party, U.S.A., in the

State of Washington.

I have been advised that you are

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------------|--|--|--|----------------------|--|--|--|
| 11160  |  |  |  |  |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |  |  |  |   |  |  |  |                                |  |  |  | 11168                |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <sup>First</sup> Florence <sup>Middle</sup> O'Dell <sup>Last</sup> Lynch   |  |  |  |  |  |  |  |   |  |  |  | 2a. DATE OF DEATH<br>Month 8 Day 20 Year 68   |  |  |  |   |  |  |  |                                |  |  |  | 2b. HOUR<br>1:15 A M |  |  |  |
| 3. SEX<br>F.   |  |  |  | 4. RACE<br>W   |  |  |  | 5. DATE OF BIRTH<br>11-3-73   |  |  |  | 6. AGE (In years<br>lost birthday)<br>94 YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS            |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |                      |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Harrisonville,<br>Balto. Co., Md.   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Chesapeake Manor N. Wm. Housewife |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Own Home  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE Md.   |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  | 13c. CITY OR TOWN<br>Dundalk  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br>1734 Lynch Road |  |  |  |                                |  |  |  |                      |  |  |  |
| 14. FATHER'S NAME<br><sup>First</sup> J. <sup>Middle</sup> Dickson <sup>Last</sup> O'Dell  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><sup>First</sup> Sarah <sup>Middle</sup> E. <sup>Last</sup> Holbrook                     |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-44-4161J-1   |  |  |  | 17. INFORMANT<br>Edwin O. Lynch   |  |  |  | Address<br>(Same)   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br><u>4369</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Chronic Brain Syndrome</u><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Generalized arteriosclerosis</u><br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)<br><u>331X</u>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                      |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 10</u> , 19 <u>68</u> , to <u>August 7</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>August 10</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 22b. SIGNATURE<br><u>JAMES H. HAMEL</u>  |  |  |  | DEGREE<br>M.D.   |  |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  |  |  | 22c. DATE SIGNED<br><u>8/20/68</u>  |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>JAMES H. HAMEL, M.D.  |  |  |  | 22e. ADDRESS<br>TOWSON 4, MD.  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  |  | 23b. DATE<br>8/23/68   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Balto. Co., Md.                        |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>H.W. Jenkins & Sons Co.  |  |  |  | ADDRESS<br>4905 York Road<br>Balto. 12, Md.  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 22 1968   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |   |  |  |  |                                |  |  |  |                      |  |  |  |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |         |  |                                 |  |  |   |  |   |  |  |  |
|--|---------|--|---------------------------------|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |                                 | Middle   |  | Last  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
| NANCY  |         | RITA   |                                 | MAENNER  |  |   |  | Month Day Year  |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday) | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |
| female   | white   | 5/28/1916  | 52 YRS.                         | MONTHS DAYS  |  | HOURS MIN.  |  | Month Day Year  |  | M  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |  |  |
| Md.  |         | U.S.A.   |                                 |  |  | Baltimore   |  |   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |  |  |
| Baltimore (Towson)   |         | St. Josephs Hospital   |                                 | Asst. Mgr. Farm Store  |  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                                 | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |  |  |
| Maryland   |         | BALTO  |                                 | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5304 Moreword   |  |  |  |
| 14. FATHER'S NAME  |         | First  |                                 | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last                            |  |
| IM   |         | - Kelly  |                                 | Rita   |  | - Unknown   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |                                 | 17. INFORMANT  |  | ADDRESS   |  |   |  |  |  |
| no   |         | 214-20-5824  |                                 | John C. Maenner  |  | same  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                                 |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |         |  |                                 |  |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |         |  |                                 |  |  |   |  |   |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |         |  |                                 |  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |                                 |  |  |   |  |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |                                 |  |  |   |  |   |  |  |  |
| (c)  |         |  |                                 |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |                                 |  |  |   |  |   |  |  |  |
| 4221   |         |  |                                 |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?  |  |  |  |
|  |         |  |                                 |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         | 21b. TIME OF INJURY Month, Day, Year   |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |  |  |
|  |         | HOUR A.M. P.M. 19  |                                 |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                 | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County  |  | State  |  |
|  |         |  |                                 |  |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |                                 |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |         | Werner U. Spitz, M.D.  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>      |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                    |  | 22b. DATE SIGNED                             |  |
| EXAMINER'S NAME (Type)   |         |  |                                 |  |  |   |  |   |  | 8/12/68                                      |  |
|  |         |  |                                 |  |  |   |  |   |  | ADDRESS (Street, city, town, or county)      |  |
|  |         |  |                                 |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                       |  |   |  |  |  |
| Burial   |         | 8/14/68  |                                 | Baltimore National Com.  |  | Balto. Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |                                 | ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Leonard J. Ruck Inc. Balto. Md.  |         |  |                                 |  |  |   |  | DATE AUG 13 1968  |  | Charles Judge                                |  |

11103

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

11103

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



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Item 2a, Film 403 8/16 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |         |  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---------|--|------|--|----------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH                                     |  | Month                    |  | Day     |  | Year |  | 2b. HOUR |  |
| HENRY FERDINAND MAESER   |         |  |  |   |  |   |  | Aug. 10   |  | 19                       |  | 68      |  | 2:50 |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |  | 7c. DATE PRONOUNCED DEAD |  | Month   |  | Day  |  | Year     |  |
| Male   | White   | 7-28-1905  |  | 63 YRS  |  | MONTHS  |  | DAYS  |  | August 10,               |  | 19      |  | 68   |  | M        |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |  |                          |  |         |  |      |  |          |  |
| Maryland   |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore   |  |                          |  |         |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |         |  |      |  |          |  |
| Arbutus  |         | 1233 Greystone Road  |  | Shipping Clerk  |  | Butter & Eggs   |  |   |  |                          |  |         |  |      |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                                      |  |                          |  |         |  |      |  |          |  |
| Maryland   |         | Baltimore  |  | Arbutus   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1233 Greystone Road   |  |                          |  |         |  |      |  |          |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME                                    |  | First                    |  | Middle  |  | Last |  |          |  |
| Henry Ferdinand Maeser   |         |  |  |   |  |   |  | Henrietta Louise Reimenschnieder                            |  |                          |  |         |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                          |  |         |  |      |  |          |  |
| No   |         | 212-07-8716  |  | Mrs. Anna L. Maeser, 1233 Greystone Road  |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | CORONARY THROMBOSIS   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  | 1 HOUR                   |  |         |  |      |  |          |  |
| 4100   |         | DUE TO, OR AS A CONSEQUENCE OF   |  | (b)   |  | HYPERTENSIVE CV DISEASE   |  | 6 YRS   |  |                          |  |         |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  | PULMONARY EMPHYSEMA   |  | 6 YRS   |  |                          |  |         |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         | 4201   |  | DIABETES  |  | GLAUCOMA.   |  |   |  |                          |  |         |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                          |  |         |  |      |  |          |  |
| NONE   |         |  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |   |  |                          |  |         |  |      |  |          |  |
|  |         | HOUR A.M. P.M.   |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State                    |  |         |  |      |  |          |  |
|  |         |  |  |   |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                 |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED         |  | 8/12/68 |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | John N. Snyder   |  | M.D.  |  |   |  |   |  |                          |  |         |  |      |  |          |  |
| EXAMINER'S NAME (Type)   |         | John N. Snyder   |  | ADDRESS (Street, city, town, or county)   |  | 6348 FREDERICK  |  | 21228   |  |                          |  |         |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)  |  | (State)                  |  |         |  |      |  |          |  |
| Burial   |         | 8-13-1968  |  | Loudon Park Cemetery  |  | Baltimore, Maryland   |  |   |  |                          |  |         |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                          |  |         |  |      |  |          |  |
| Howard H. Hubbard, 4107 Wilkens Ave.   |         | 21229  |  | DATE  |  | AUG 13 1968   |  | y Charles Judge   |  |                          |  |         |  |      |  |          |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 11163  |  |                         |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  |  |  |  |  |  |  | 11171                |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|----------------------|--|------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print) First Middle Last<br><b>PAUL MICHAEL MAISEL</b>   |  |                         |  |  |  |   |  |  |  | 2a. DATE KNOWN OF ESTI-DEATH MONTH DAY YEAR<br><b>August 19 1968</b>        |  |   |  |  |  |  |  |  |  | 2b. HOUR<br><b>M</b> |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>7/12/30</b>   |  | 6. AGE (In years last birthday)<br><b>38</b> YRS. |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>August 21 1968</b>  |  |  |  |  |  |  |  |                      |  | 2d. HOUR<br><b>3:30 P.M.</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  |  |  |  |  |                      |  | Md.                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1005 Frederick Road</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>UNKNOWN</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>  |  |   |  | 13c. CITY OR TOWN<br><b>CATONS.</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>1005 Frederick Road</b> |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>GEO. J. MAISEL</b>   |  |                         |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>RUTH E. CHILDS</b>         |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>216287613</b>   |  |   |  | 17. INFORMANT ADDRESS<br><b>CAROL WILTSE</b>   |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |                         |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. 19 P.M.  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>  |  |                         |  | EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |  |   |  | M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |  |  | 22b. DATE SIGNED<br><b>August 22, 1968</b> |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>8/27/68</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATL.</b>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>  |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. MALNABD</b>  |  |                         |  | ADDRESS<br><b>21228</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>AUG 28 1968</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |  |  |                      |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |  |  |  |
| 11164  |  |   |  |   |   |   |  |  |  |
| 11172  |  |   |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Dahlia</i>  |  |   | First <i>N.</i> Middle <i>malinowski</i> Last          |   |   | 2a. DATE OF DEATH<br>Month <i>8</i> Day <i>17</i> Year <i>68</i>                                |  | 2b. HOUR<br><i>4:15</i> M                          |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH<br><i>2-1-09</i>   |   | 6. AGE (In years last birthday)<br><i>59</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>U.S. Va.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>BALTIMORE</i> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>RANDALLSTOWN</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>BALT. CO. GEN. HOSP.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>1811 Colonial Rd.</i> |  |
| 14. FATHER'S NAME<br><i>Adnorm J. Swift</i>  |  |   | First <i>Adnorm</i> Middle <i>J.</i> Last <i>Swift</i> |   |   | 15. MOTHER'S MAIDEN NAME<br><i>Ida Blanch Swan</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><i>218-07-5105</i>  |   | 17. INFORMANT<br><i>HOSPITAL RECORDS</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |   |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of the Ovary</i>  |  |   |  |   |   |   |  |  |  |
| 1830 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |   |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |  |
| (c)  |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |   |  |  |  |
| 1750   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-28</i> , 19 <i>68</i> , to <i>8-17</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8-17</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Jesus C. Santiano MD</i>  |  |   |  |   | 22c. DATE SIGNED<br><i>8-17-68</i>  |   | 22d. PHYSICIAN'S NAME (Type)<br><i>Jesus C. Santiano, M.D.</i>       |  |  |
| 22e. ADDRESS<br><i>Balto., Co. General Hospital, Md.</i>   |  |   |  |   | 22f. ADDRESS  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>8/20/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Witzke, 4101 Edmondson Ave.</i>   |  |   |  |   | 25a. REC'D BY REGISTRAR<br><i>AUG 19 1968</i>                             |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>                |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |                          |   |   |  |  |  |
|---|--|--|--------------------------|---|---|--|--|--|
| 11165   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |   |   | 11173  |  |  |
| CERTIFICATE OF DEATH  |  |  |                          |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR                                     |
| GEORGE  |  |  | LEO                      |   | MALONE  | 8 26 1968  |  | 15a M  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |
| Male  |  | Caucasian  |                          | November 9, 1909  |   | 58 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |
| Lebanon, Pa.  |  | U.S.A.   |                          |   |   | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Towson  |  | Greater Balto. Med. Center   |                          | Mill Hand   |   | Beth. Steel Co   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY              |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Md.   |  |  | Baltimore                |   | Harbor View   |  | 508 S. 45th St. # 21224.   |  |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |  |  |
| Francis   |  |  | A.                       |   | Malone  | Mary M. Strainer   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address   |  |  |  |
| No  |  |  | 213-07-3559              |   | Mary M. Malone : 6623 Bushey St. #21224.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral bronchopneumonia with lung abscess and empyema<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Metastatic carcinoma of prostate<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                          |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)   |  |  |                          |   |   |  |  |  |
| 177X  |  |  |                          |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No   |   | City or Town   |  | County State                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/16 1968, to 8/26 1968, that (I) (we) last saw the deceased alive on 8/26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |                          |   |   |  |  |  |
| 22b. SIGNATURE<br>Charles C. Brown, M.D.  |  |  |                          | DEGREE<br>ATTENDING PHYS.   |   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8/26/68                  |
| 22d. PHYSICIAN'S NAME (Type)<br>Charles C. Brown, M. D.   |  |  |                          | 22e. ADDRESS<br>Greater Baltimore Medical Center  |   |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (State or country)   |  | 23b. DATE<br>8-29-68.  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Cemetery   |   | 23d. LOCATION (City or Town)<br>7401 German Hill Rd.,                                  |  | (County) (State)<br>Md.                      |
| 24. FUNERAL DIRECTOR<br>Charles S. Feiler   |  | 6224 Eastern Ave.<br>Balto., 21224, Md.                                      |                          | 25a. REC'D BY REGISTRAR<br>DATE AUG 30 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15/4A  
30M REV. 7-68

|  |  |  |        |   |   |
|--|--|--|--------|---|---|
| 11163  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |        | 11174   |   |
| CERTIFICATE OF DEATH   |  |  |        |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year   |
| LILLIAN  |  | D  |        | MARRIOTT  | 8 2 88  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |        | 5. DATE OF BIRTH<br>2/5/85  | 6. AGE (In years<br>last birthday)<br>83 YRS.   |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Md.   |
| Maryland   |  | U.S.A.   |        |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto Onty Gen Hosp |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Ironed in Laundry   |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md   |  | 13b. COUNTY<br>Balto   |        | 13c. CITY OR TOWN<br>Balto  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>First Middle Last<br>James A, Marriott Sr.  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Virginia Saum   |        | 13e. STREET AND NUMBER<br>108 Pinemere Rd.  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br>214-03-3231  |        | 17. INFORMANT<br>Mrs. Mary Kable 108 Pinemere Rd. 21117   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4510 MULTIPLE PULMONARY emboli<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOSIS of legs of lower extremities<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |        |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>TERMINAL days-weeks                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>466X   |  |  |        |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6, 1968, to Aug 2, 1968, that (I) (we) lost saw the deceased alive on Aug 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |        |   |   |
| 22b. SIGNATURE<br>Dr. Wenefredo N. Iglesias  |  |  |        | 22c. DATE SIGNED<br>8-3-68  |   |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |        | 22e. ADDRESS  |   |
| 23a. BURIAL, CREMATION,<br>(Type and city)   |  | 23b. DATE<br>August 5, 68  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |   |
| Baltimore City   |  |  |        | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore City Maryland  |   |
| 24. FUNERAL DIRECTOR<br>Loring Byers 8728 Liberty Rd. Randallstown   |  |  |        | 25a. REC'D BY REGISTRAR<br>DATE AUG 5 1968  |   |
|  |  |  |        | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |

11103

11116

RECEIVED

TO THE DIRECTOR, FBI, WASHINGTON, D.C.

FROM THE SAC, NEW YORK (100-3321)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

100-3321

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the Bureau for your information.

Very truly yours,

[Illegible Signature]

Special Agent in Charge

New York Office

Enclosure

100-3321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11167

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11175

|  |   |   |   |  |   |   |  |
|--|---|---|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |   | First<br>GEORGE   | Middle<br>DAVIS   | Last<br>MARTIN   | 2a. DATE OF DEATH<br>Month Day Year<br>8 21 1968  |   | 2b. HOUR<br>00p M  |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>August 6, 1920  |  | 6. AGE (In years<br>last birthday)<br>48 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Georgia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Med. Center |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Eng.  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Ceramic   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Glendale  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br>905 Pemberton Rd.                                 |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Paul A. Martin   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Leona Meares                   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)<br>WW II   |   | 16b. SOCIAL SECURITY NO.<br>245 18 2283   |   | 17. INFORMANT<br>Address<br>June A. Martin 905 Pemberton Rd.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malignant melanomatosis</u><br>1729<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |   |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1909   |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? YES |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/21, 1968</u> , to <u>8/21, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>8/21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.                                     |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><i>Rudiger Breitenecker</i>  |   |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>8/22/68   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Rudiger Breitenecker, M.D.   |   |   |   | 22e. ADDRESS<br>Greater Baltimore Medical Center   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |   | 23b. DATE<br>8/25/1968  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Lawn Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Charlotte, N. Carolina     |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Mitchell Wiedefeld Home 6500 York Rd.   |   |   |   | 25a. REG'D BY REGISTRAR<br>DATE<br>AUG 26 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                            |  |

11175

COMMUNIST PARTY

11175

August 3, 1950

W.S.A.

George

Baltimore, Maryland

Leona

Martin

1515 15th Ave. S.E. Washington, D.C.

*Handwritten signature*

Official 8/23/50 Forst Lane (Mrs) Charlotte, N. Carolina

Michael M. Smith Home 200 York St.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |   |                                |  |
|--|--|--|--|---|---|---|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |   |                                |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Lost  | 2a. DATE OF DEATH<br>Month Day Year   |   |                                | 2b. HOUR   |
| Martha   |  |  | V.   | Matthews  |   | August 9 1968   |   |                                | 1:35 PM  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| F  |  | W  |  | April 8 1885  |   | 83  |   | YRS.                           |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                |  |
| Md.  |  | U.S.A.   |  |   |   | Baltimore Md.   |   |                                |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| Baltimore  |  |  | Summit Nursing Home  |   |   | Housewife   |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                | 13e. STREET AND NUMBER                                       |
| Md.  |  |  | Balto.   |   | Balto   |   | YES   |                                | 244 S. Monastery Ave., 29                                    |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Lost  | 15. MOTHER'S MAIDEN NAME  |   |                                |  |
| Stephen Kirby  |  |  |  |   |   | Mary M.   |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT   |   |                                |  |
| Yes, no, or unknown  |  |  | --   |   |   | Mr. Harry E. Matthew, Jr., 421 Margaret Hwe.  |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Soyemia</u><br><u>1739</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Obstruction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 Dgs.</u> |  |  |  |   |   |   |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>191.9 Squamous Cell Car of Skin (Skin)</u>  |  |  |  |   |   |   |   |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                |  |
|  |  |  |  |   |   |   |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |                                |  |
|  |  |  |  |   |   |   |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |                                |  |
|  |  |  |  |   |   |   |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>68</u> , to <u>8/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                               |  |  |  |   |   |   |   |                                |  |
| 22b. SIGNATURE <u>Cliff Batlif Jr</u>  |  |  |  |   | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                | 22c. DATE SIGNED <u>8/10/68</u>                              |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Cliff Batlif, Jr.</u>  |  |  |  |   | 22e. ADDRESS <u>4605 Edmondson Ave., Balto., Md. 21229</u>                        |   |   |                                |  |
| 23a. BURIAL, CREMATION, (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |   |                                |  |
| Burial   |  | 8/12/68  |  | Chestertown Cemetery  |   | Chestertown, Md.  |   |                                |  |
| 24. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., Balto., Md.</u>   |  |  |  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |                                |  |
|  |  |  |  |   | DATE <u>AUG 13 1968</u>   |   |   |                                |  |

07111

07111

RECORDS OF DEATH

March 9 1902

Marshall

Marshall

April 8 1902

W

W

Marshall

X

U.S.A.

Mr.

Marshall

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11169

11177

|   |  |                                   |  |  |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|---|--|--|--|---|--|---|--|----------------------|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>BALTO.</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u><br>c. LENGTH OF STAY IN lb<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House of Pines Nursing Home</u>                |  |                                   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission)<br>a. STATE <u>MD</u> <b>✓</b> COUNTY _____<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u><br>d. STREET ADDRESS <u>924 FRANKLINTOWN RD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Daisy B. Mc Coy</u><br>First Middle Last  |  |                                   |  | <b>4. DATE OF DEATH</b> <u>8 - 28</u> 19 <u>68</u><br>Month Day Year   |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>5. SEX</b> <u>F</u>  |  | <b>6. COLOR OR RACE</b> <u>C.</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b> <u>6 - 7 - 97</u>   |  | <b>9. AGE</b> (In years last birthday) <u>71</u> yrs.  |  | <b>IF UNDER 1 YEAR</b> Months _____ Days _____                |  | <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____  |  |                      |  |  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>  |  |                                   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N.C.</u>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) _____   |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> _____   |  |                      |  |  |  |  |  |
| <b>13. FATHER'S NAME</b> <u>?</u>   |  |                                   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>META MCCALLISTER</u>  |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes give war or dates of service) _____  |  |                                   |  | <b>16. SOCIAL SECURITY NO.</b> _____   |  |   |  | <b>17. INFORMANT</b> <u>RASSIE Mc Coy</u> Address <u>4911 ST. Georges Ave</u>  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u><br><u>180 X</u> DUE TO <u>Carcinoma Cervix</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ |  |                                   |  |  |  |   |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>6 mo.</u><br><u>231</u>                                 |  |                      |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>171 X</u>  |  |                                   |  |  |  |   |  |  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____   |  | Month, Day, Year _____ 19 _____   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ |  | <b>20f. (City or town)</b> _____   |  | <b>(County)</b> _____   |  | <b>(State)</b> _____  |  |                      |  |  |  |  |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>8-15</u> , 19 <u>68</u> , to <u>8-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-26</u> , 19 <u>68</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.                               |  |                                   |  |  |  |   |  |  |  |   |  |   |  |                      |  |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Wilmer K. Gallagher</u> M.D.   |  |                                   |  |  |  |   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  |   |  | <b>22b. DATE SIGNED</b> <u>8/29/68</u>  |  |                      |  |  |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Wilmer K. Gallagher, M.D.</u>  |  |                                   |  |  |  |   |  | <b>22d. ADDRESS</b> <u>6207 Frederick Ave. Balt. Md. 21228</u>   |  |   |  |   |  |                      |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>  |  |                                   |  | <b>23b. DATE THEREOF</b> <u>8-31-68</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ARBUTUS MEM. PK</u>                    |  |  |  | <b>23d. LOCATION (City, town or county)</b> <u>ARBUTUS MD</u> |  |   |  | <b>(State)</b> _____ |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph G. Locks Jr</u>   |  |                                   |  |  |  |   |  | <b>ADDRESS</b> <u>1304 7th CENTRAL AVE</u>   |  |   |  | <b>25a. REC'D BY REGISTRAR</b> <u>AUG 30 1968</u>   |  |                      |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u> |  |  |  |

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APR 20 1968

*Handwritten signature*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

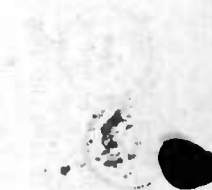
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| 11170  |  |  |  |  |  |  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 11178   |  |  |  |  |                                |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Samuel Montimer Mc Kenney  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>August Month 30, Day 1968  |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>5:30 P M  |  |  |  |  |                                |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>August 18, 1893   |  |  |  |  | 6. AGE (In years last birthday)<br>75 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto. Co. Md.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Glyndon   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>307 Central Ave. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)<br>Manager of Chemical Co. in Office                                  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  |  |  | 13b. COUNTY<br>Balto.  |  |  |  |  | 13c. CITY OR TOWN<br>Glyndon  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>307 Central Ave.                                |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>M. W. Mc Kenney   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Carrick  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)<br>WW I   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-05-6689  |  |  |  |  | 17. INFORMANT Address<br>Mrs. Janet M. Chilcoat Glyndon, Md.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>67 A.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Emphysema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4201 |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>few hours<br>years<br>years                     |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION<br>✓  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>✓   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>✓ |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>✓  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br>✓            |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>✓                |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>✓   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1-1940, to 8-30-68, 19, that (I) (we) last saw the deceased alive on 8-30-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE<br>James G. Saffell MD  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  |  | 22c. DATE SIGNED<br>8-31-68   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>James G. Saffell MD  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>Reisterstown, Md  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>Sept. 2, 68   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>All Saints Cemetery   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Reisterstown, Md.                              |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>J. F. Eline & Sons   |  |  |  |  |  |  |  |  |  | ADDRESS<br>Reisterstown, Md.  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 3 1968  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge                            |  |  |  |  |                                |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| <div style="display: flex; justify-content: space-between;"> <div> 11172 </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH<br/> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div> <div> 11179 </div> </div>   |  |   |  |   |  |  |   |   |  |   |                                |
|--|--|---|--|---|--|--|---|---|--|---|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>JEROME MC LEOD</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>8 9 68</b>   |   |   | 2b. HOUR<br><b>4:00AM</b>                                |   |                                |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br><b>5/31/14</b>  |  |  | 6. AGE (In years last birthday)<br><b>54</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS                           |   | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>  |   |   | Md   |   |                                |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>                              |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b> |   |                                |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MD</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER<br><b>1361N. Stricker Street</b>                         |  |   |                                |
| 14. FATHER'S NAME First Middle Last<br><b>CHARLIE MC LEOD</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>DAISY CHAPMAN</b>  |  |  |   |   |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 217 18 65 02</b>   |  | 17. INFORMANT Address<br><b>VA HOSPITAL, FT HOWARD, MD. CLINICAL RECORDS</b>  |  |  |   |   |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA, RIGHT LUNG WITH METASTASIS TO LUNG,</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEART AND ADRENAL</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>163X</b> |  |   |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b> |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>ARTERIOSCLEROSIS, GENERALIZED</b>   |  |   |  |   |  |  |   |   |  |   |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> |  |   |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |   |  |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |   |                                |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>7/24/68</b> to <b>8/9/68</b> , 19____, that (b) (we) lost saw the deceased alive on <b>8/9/68</b> 19____, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |   |  |   |                                |
| 22b. SIGNATURE<br><b>J. D. Talbert, M.D.</b>   |  |   |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/9/68</b>   |  |   |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |   |   |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-13-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>     |  |   |                                |
| 24. FUNERAL DIRECTOR<br><b>Vernon R. Bailey, Mgr.</b>  |  |   |  | ADDRESS<br><b>KELSON FUNERAL HOME</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 13 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                              |  |   |                                |

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DEPARTMENT OF JUSTICE

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NOV 10 1958

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |  |  | 11180  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 11172  |  |
| 1. DECEASED-NAME<br>(Type or Print) <u>Earl</u> <u>I</u> <u>McMillan, Sr.</u>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>8</u> Day <u>22</u> Year <u>1968</u>  |  | 2b. HOUR <u>M</u>  |  |  |  |
| 3. SEX <u>Male</u>   |  | 4. RACE <u>White</u>   |  | 5. DATE OF BIRTH <u>3-14-05</u>   |  | 6. AGE (In years last birthday) <u>63</u> YRS.   |  | IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>  |  | IF UNDER 24 HRS. HOURS <u>  </u> MIN <u>  </u>         |  |
| 7a. BIRTHPLACE (State or foreign country) <u>N.C.</u>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>Balto.</u>   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH <u>Towson</u>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St Joseph Hosp.</u> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Expediter</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>   |  |  |  | 13b. COUNTY <u>Balto.</u>   |  | 13c. CITY OR TOWN <u>Balto.</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET AND NUMBER <u>2803 Evergreen Ave</u>       |  |
| 14. FATHER'S NAME First <u>Leander Fields</u> Middle <u>McMillan</u> Last <u>  </u>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME First <u>Jincy Ann</u> Middle <u>Bennett</u> Last <u>  </u>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16b. SOCIAL SECURITY NO. <u>213-10-1521</u>   |  | 17. INFORMANT <u>Margaret L. McMillan, 2803 Evergreen Ave.</u>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109</u> <u>Coronary Occlusion Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease</u> <u>2 yrs</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>  </u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <u>  </u>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>  </u>   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |  |  | 21b. TIME OF INJURY Month, Day, Year <u>  </u> A.M. <u>  </u> P.M. <u>19</u>                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>  </u>  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>  </u> |  |   |  | 21f. LOCATION Street or R.F.D. No. <u>  </u>   |  | City or Town <u>  </u>   |  | County <u>  </u> State <u>  </u>                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | 22b. DATE SIGNED <u>8/22/68</u>  |  |  |  |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| ADDRESS (Street, city, town, or county) <u>  </u>  |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>8-26-68</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>  |  |  |  | 23d. LOCATION (City or Town) <u>Balto., Md.</u> (County) <u>  </u> (State) <u>  </u>                     |  |  |  |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR <u>AUG 23 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

## References

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11173  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11181   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Joseph E. McNally  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Aug. 25, 1968   |  |  |  |  |  |  |  |  |  | 6:25am  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  |  |  |  |  |  | 4. RACE<br>White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>2-21-1916   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)<br>52 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Mass.   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hosp.   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Security Officer   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Parkville  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>3047 California Avenue                     |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>William McNally   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Mary Hanson  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes or unknown   |  |  |  |  |  |  |  |  |  | (If yes give work dates of service)<br>W.W.2   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-18-1636   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Anna McNally   |  |  |  |  |  |  |  |  |  | Address<br>3047 California Ave.                                      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Extensive myocardial infarction.</u><br><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |  |  |  |  |  |  |  |  | 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 24, 1968</u> , to <u>August 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><i>Christina Feliciano</i>   |  |  |  |  |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>August 25, 1968   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Christina Feliciano, M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE<br>8/28/68   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Balto. Md.  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>AUG 26 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Judge</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792

• *Walden* by Henry David Thoreau

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11174

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11182

CERTIFICATE OF DEATH

|   |  |  |  |   |  |   |   |  |   |         |
|---|--|--|--|---|--|---|---|--|---|---------|
| 1. DECEASED-NAME<br>(Type or print) <b>LAVRA V. MEEHAN</b>  |  |  | 2a. DATE OF DEATH<br>8 Month 21 Day 68 <sup>Year</sup> |   |  | 2b. HOUR<br>8:45 A M  |   |  |   |         |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>8/18/93</b>  |  | 6. AGE (In years<br>last birthday) <b>75</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN           |   |         |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b>   |   |  |   |         |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>SUMMIT HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>R.N.</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>RET.</b>  |   |  |   |         |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <b>MD</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>CATONS.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1703 FREDERICK RD</b> |   |         |
| 14. FATHER'S NAME<br><b>NEIL J. MEEHAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>VIRGINIA V. EGER</b>    |   |  |   |   |  |   |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>219309088</b>           |   | 17. INFORMANT<br><b>MARGUERITE MEEHAN</b>  |   |   |  | Address   |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Paralysis agitans - severe</b><br><b>342X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 yrs +</b> |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>350X arteriosclerotic cardiovascular disease</b>  |  |  |  |   |  |   |   |  |   |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                    |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County   |   | State   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Dec 3, 1964</b> , to <b>Aug 21, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>Aug 16, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |   |   |  |   |         |
| 22b. SIGNATURE<br><b>John A. Nesbitt Jr.</b>  |  |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                       |  | 22c. DATE SIGNED<br><b>8-21-68</b>  |   |  |   |         |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>JOHN A. NESBITT JR</b>   |  |  |  | 22e. ADDRESS<br><b>1009 Frederick Rd., Baltimore Md 21228</b>   |  |   |   |  |   |         |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><b>8/23/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CATHEDRAL</b>  |  | 23d. LOCATION (City or Town)  |   | (County)   |   | (State) |
| <b>BURIAL</b>   |  |  |  |   |  | <b>BALTO. MD.</b>   |   |  |   |         |
| 24. FUNERAL DIRECTOR<br><b>E.C. MACNABB</b>   |  |  |  | ADDRESS<br><b>21228</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 22 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |         |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |   |  |                                  |  |
|--|--|--|--|---|--|---|--|---|--|----------------------------------|--|
| 11175  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 11183   |  |                                  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>E. LOUISE MEISE</b>   |  |  |  | 2a. DATE OF DEATH<br><b>8</b> Month <b>14</b> Day <b>1968</b>   |  |   |  | 2b. HOUR<br><b>1:00</b> P.M.                        |  |                                  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br><b>12-16-1917</b>   |  | 6. AGE (In years last birthday)<br><b>50</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                   |  | IF UNDER 24 HRS.<br>HOURS<br>MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |   |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>1</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>600 N. CHESTER ST.</b> |  |                                  |  |
| 14. FATHER'S NAME<br><b>WALTER L. OGIER</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>LAURA BIDDISON</b>  |  |   |  |   |  |   |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br><b>Mr. Walter R. Meise - 600 N. Chester St.</b> Address  |  |   |  |   |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>340 X</b> IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>345 X</b>   |  |  |  |   |  |   |  |   |  |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1967</b> , to <b>8/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |                                  |  |
| 22b. SIGNATURE<br><b>Joseph R. Liberto, MD</b> DEGREE  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/17/68</b>  |  |   |  |                                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOSEPH R. LIBERTO, MD</b>   |  |  |  | 22e. ADDRESS<br><b>7308 BANK ST. - Balto Md 21244</b>   |  |   |  |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-17-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                              |  |   |  |                                  |  |
| 24. FUNERAL DIRECTOR<br><b>Shirley Miller - 2334 Jefferson St.</b> ADDRESS   |  |  |  | 25a. RECEIVED BY REGISTRAR<br><b>AUG 16 1968</b> DATE   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>  |  |   |  |                                  |  |

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11183 11173

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11176

11184

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                         |   |                     |   |  |  |                      |
|---|-------------------------|---|---------------------|---|--|--|----------------------|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>Leonard</b>   | Middle<br><b>J.</b> | Last<br><b>Meninger Sr.</b>   | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>Aug. 8 1968</b> |  | 2b. HOUR<br><b>M</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Jan. 23, 1893</b>  |                     | 6. AGE (In years last birthday)<br><b>75</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b>  | MIN.<br><b>0</b>     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |                      |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8422 Harris Ave.</b> |                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Carpenter - Contracting Work</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |                     | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |
| 14. FATHER'S NAME<br><b>William Meninger</b>  |                         | 15. MOTHER'S MAIDEN NAME<br><b>Florence Gross</b>   |                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |  |                      |
| 16b. SOCIAL SECURITY NO.<br><b>216-10-3142A</b>   |                         | 17. INFORMANT (Wife)<br><b>Mrs. Mary C. Meninger, 6701 North Pt. Rd.</b>                                |                     | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACVD - arteriosclerotic Cord</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 High Heat at work site - a + mosquito</b>   |                         |   |                     |   |  |  |                      |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M.                                     |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                      |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |                     | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |                     |   |  |  |                      |
| ACTUAL SIGNATURE<br><b>John C. Hyle</b>   |                         | EXAMINER'S NAME (Type)<br><b>John C. Hyle M.D.</b>  |                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>Aug. 8, 1968</b>  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>8/13/68</b>   |                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |                      |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |   |                     | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 12 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                      |

1990

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|----------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First<br>Rena  |  |  | Middle<br>H.   |  |  | Last<br>MERRIKEN  |  |  | 2a. DATE OF DEATH<br>8 Month 7 Day 68 Year                           |  |  | 2b. HOUR<br>10 <sup>10</sup> P M |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>white   |  |  | 5. DATE OF BIRTH<br>8-6-1880   |  |  | 6. AGE (In years last birthday)<br>88 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>America  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson, Md.   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Chesapeake Manor Nrs. Home |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—  |  |  |  |  |  |                                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>8204 Loch Raven Blvd BALTO.   |  |  | 13b. COUNTY<br>BALTO.  |  |  | 13c. CITY OR TOWN<br>BALTO.  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>8204 Loch Raven Blvd                       |  |  |                                  |  |  |
| 14. FATHER'S NAME First<br>William   |  |  | Middle<br>McConnell  |  |  | Last<br>—  |  |  | 15. MOTHER'S MAIDEN NAME First<br>Mary-Jane   |  |  | Middle<br>S.   |  |  | Last<br>Clayton                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br>no   |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>220-48-8392  |  |  | 17. INFORMANT Address<br>Owen McConnell (Nephew)<br>8158 Loch Raven Blvd. Towson 21204          |  |  |  |  |  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypostatic bronchopneumonia</u><br>4369<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cerebrovascular accident - Chronic Brain Syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized arteriosclerosis</u> |  |  |  |  |  |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |  |  |  |                                  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |  |  |  |                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1968</u> , to <u>August 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 3, 1968</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |  |
| 22b. SIGNATURE<br>Jamshid Hamed  |  |  | DEGREE<br>M.D.   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  | 22c. DATE SIGNED<br>Aug. 9. 1968  |  |  |  |  |  |                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>JAMSHID HAMED  |  |  | 22e. ADDRESS<br>204 E. Joppa Rd. Towson Md. 21204  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>Aug. 12. 1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cem.  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Arlington Va.                                  |  |  |  |  |  |                                  |  |  |
| 24. FUNERAL DIRECTOR<br>HENRY SANDER & SONS, INC.  |  |  | ADDRESS<br>Baltimore Md.   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 12 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |  |                                  |  |  |

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THE UNIVERSITY OF CHICAGO PRESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |                                     |
|--|--|--|--|---|--|---|--|--|-------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                                     |
| 11178 CERTIFICATE OF DEATH 11186   |  |  |  |   |  |   |  |  |                                     |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR P                          |
| WALTER   |  |  | PETER  |   |  | MILANICZ  |  |  | August Month 23 Day 1968 Year 1:15M |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |                                     |
| Male   |  | White  |  | June 20 1913  |  | 55 YRS.   |  | IF UNDER 24 HRS<br>HOURS MIN                                   |                                     |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                                     |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore Md.   |  |  |                                     |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                     |
| Fort Howard  |  |  | Hospital Veterans Administration                                 |   |  | Butcher   |  |  |                                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER              |
| Maryland   |  |  |  |   | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 1803 Aliceanna Street-21            |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |  |                                     |
| First Middle Last  |  |  | First Middle Last  |   |  |   |  |  |                                     |
| ROBERT   |  |  | MILANICZ   |   |  | AGNES   |  |  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |  |                                     |
| Yes WW-11  |  |  | 219 26 23 16   |   | Clinical Reds, VA Hospital, Fort Howard, Md.   |   |  |  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u><br><u>011.3</u> DUE TO, OR AS-A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY TUBERCULOSIS, ACTIVE</u><br>DUE TO, OR AS-A CONSEQUENCE OF (c) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>WEEKS<br>YEARS |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><u>0021</u> COR PULMONALE, CHR.   |  |  |  |   |  |   |  |  |                                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                                     |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                                     |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>Aug. 10</u> , 19 <u>68</u> , to <u>Aug. 23</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Aug. 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |   |  |   |  |  |                                     |
| 22b. SIGNATURE   |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |                                     |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   | 22e. ADDRESS   |   |  |  |                                     |
| MARIO J. QUIROS, M.D.  |  |  |  |   | VA Hospital, Fort Howard, Maryland   |   |  |  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Type)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                     |
| REMOVAL (Type)   |  | 444 27, 1968   |  | Balto. National Cemetery  |  | Baltimore, Maryland   |  |  |                                     |
| 24. FUNERAL DIRECTOR   |  | 25. ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                                     |
| Joseph N. Zannino  |  | 2573. Conkling St.   |  | AUG 26 1968   |  | Charles Judge   |  |  |                                     |
| Joseph N. Zannino Funeral Home Balto. Md.  |  |  |  |   |  |   |  |  |                                     |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>NELLIE</b>   |  | First<br><b>M.</b>   |  | Middle<br><b>MILEY</b>  |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>21</b> Year <b>1968</b> |  |   |  | 2b. HOUR<br><b>6.40 PM</b>                   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>1-20-1885</b>  |  |   |  | 6. AGE (In years last birthday)<br><b>83</b> YRS.                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET AND NUMBER<br><b>3602 Harford Rd., -21218</b>               |  |   |  |  |  |
| 14. FATHER'S NAME<br><b>Ferdinan</b>   |  | First<br><b>Nace</b>   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary</b>                                 |  | First<br><b>?</b>                         |  | Middle<br><b>?</b>                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b>  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-4468</b>  |  | 17. INFORMANT<br><b>Mrs. Mary Kimball</b>   |  | Address<br><b>(Same)</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cholecystitis</b>   |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>8-18-1968</b> , to <b>8-21-1968</b> , that <b>I</b> (we) last saw the deceased alive on <b>8-21-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William</b>   |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/22/68</b>  |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson Md. 21204</b>   |  |   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/24/68.</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ANNIE LORETTA MILLAR</b>  |  |   | 2a. DATE OF DEATH<br><b>8</b> Month <b>2</b> Day <b>68</b> ar  |  | 2b. HOUR<br><b>11 AM</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br><b>May 23 1887</b>  |  | 6. AGE (In years<br>last birthday)<br><b>81</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>GR. BALTO. MED. CENTER</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>At Home</b> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Parkville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 13e. STREET AND NUMBER<br><b>2903 2nd. Ave.</b>                                      |  |
| 14. FATHER'S NAME First <b>STEPHEN</b> Middle <b>McAvoy</b> Last <b>McAvoy</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>White</b> Last   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (na, or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Family Records</b> Address                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1621</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>CARCINOMA OF THE LUNG WITH METASTASIS</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>163x</b> <b>DIABETES MELLITES</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> at home  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/6</b> , 19 <b>68</b> , to <b>8/2</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>8/2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Derek A Bruce</b> DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>PHYS. DIRECTOR PHYS.   |  |   |  | 22c. DATE SIGNED<br><b>8/2/68</b>  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Dr. Derek A. Bruce M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>GBMC</b>  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/5/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cem. Balto Co Md</b>      |  |
| 24. FUNERAL DIRECTOR<br><b>C. F. EVANS &amp; SON 8802 Harford road</b>   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 5 1968</b>   |  |
| VR A15, 2/68<br>30M REV. 1/68  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                 |  |

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## CERTIFICATE OF DEATH

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|   |  |  |   |   |   |   |   |  |
|---|--|--|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  | Middle  | Lost  | 2a. DATE OF DEATH                             |   | 2b. HOUR                                  |  |
| Anthony   |  | =Joseph  | MILLER  | Sr.   | 8 Month 29 Day 68 Year                        |   | 8:15 P M                                  |  |
| 3. SEX  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)               |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| Male  | Cau  |  | July 11, 1885   |   | 83 YRS.                                       |   |   |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                            |   |   |  |
| Lithuania   | Lithuania  |  |   |   | Baltimore Md.                                 |   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY             |   |   |  |
| Baltimore   | Greater Balto. Med. Center   |  | Tailor  |   |   |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE  | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 | 13e. STREET AND NUMBER                        |   |   |  |
| Maryland  |  |  | Baltimore   |   | 5727 Cedonia Ave                              |   |   |  |
| 14. FATHER'S NAME   | First  | Middle   | Lost  | 15. MOTHER'S MAIDEN NAME  |   | First   | Middle                                    | Lost   |
| Joseph  |  | Miller   |   | Unknown   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address   |   |  |
| No  |  | 218-32-1229  |   | Nellie Ann Miller   |   | Same  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral confluent bronchopneumonia</u><br><u>153.8</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic carcinoma of the colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>153.8</u>   |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>68</u> , to <u>8/29</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Charles C. Brown, M.D.</u>   |  | DEGREE   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>8/30/68   |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |   |   |   |   |   |  |
| Charles C. Brown, M.D.  |  | 6701 N. Charles Street   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State) |   |   |  |
| Burial  |  | 9/3/68   | Holy Redeemer   |   | Baltimore, Maryland                           |   |   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |   |  |
| Leonard J Ruck Inc  |  | Baltimore, Maryland  |   | SEP 3 1968  |   | <u>Charles Judge</u>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |                                   |   |
|---|--|--|--|--|---|--|--|-----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |                                   |   |
| 11182 CERTIFICATE OF DEATH 11190  |  |  |  |  |   |  |  |                                   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  | First Middle Last  |   | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR  |
| MADALENE  |  |  |  | NMN MILLER   |   | 8 Month 27 Day 68 Year   |  |                                   | 6:35 p.m.   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday)  |                                   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| Female  |  | Cau  |  | June 24, 1901  |   |  | 67 YRS.  |                                   |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |   |
| Baltimore, Md.  |  | U. S. A.   |  |  |   | Baltimore Md.  |  |                                   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Baltimore   |  | Greater Balto. Med. Center   |  |  | Ret. Packer   |  |  | Gen'l Chemical                    |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |
| Maryland  |  |  |  | Baltimore  |   |  |  | 1410 Locust Street 21226          |   |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |  |                                   |   |
| Harry Hoffman   |  |  |  | Mary Parks   |   |  |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |                                   |   |
| No  |  |  |  | 215-12-1853  |   | Mrs Eileen Langville 1410 Locust Street 21226  |  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   |  |  |                                   |   |
| IMMEDIATE CAUSE (a) Carcinoma of bladder and lung with  |  |  |  |  |   |  |  |                                   |   |
| 188x DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |  |                                   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Liver metastasis   |  |  |  |  |   |  |  |                                   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) Lung metastasis  |  |  |  |  |   |  |  |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |                                   |   |
| 1992  |  |  |  |  |   |  |  |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)  |   |  |  |                                   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |                                   | County State  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/14, 19 68, to 8/27, 19 68, that (I) (we) last saw the deceased alive on 8/27, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |   |
| 22b. SIGNATURE Charles C. Brown, M.D. DEGREE  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 8/28/68   |                                   |   |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.   |  |  |  |  | 22e. ADDRESS 6701 N. Charles Street   |  |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  | A. A. Co. Md                      |   |
| Burial  |  | 8/30/68  |  | Cedar Hill   |   | Ritchie Highway  |  |                                   |   |
| 24. FUNERAL DIRECTOR McCully F.A. ADDRESS 237 Patapsco Ave. 21225   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE AUG 30 1968  |  | 25b. REGISTRAR'S SIGNATURE [Signature]                                   |                                   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

|  |  |   |       |   |  |   |   |   |                               |
|--|--|---|-------|---|--|---|---|---|-------------------------------|
| 11183  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |       |   |  | 11191   |   |   |                               |
| CERTIFICATE OF DEATH   |  |   |       |   |  |   |   |   |                               |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR  |                               |
| ELIZABETH  |  |   | R     |   | MITCHELL   | AUGUST 3, 1968  |   | 8:00a.M   |                               |
| 3. SEX   |  | 4. RACE   |       | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  | IF UNDER 24 HRS.<br>HOURS MIN |
| FEMALE   |  | WHITE   |       | NOVEMBER 1, 1891  |  | 76  |   |   |                               |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   | Md  |                               |
| MARYLAND   |  | U.S.A.  |       |   |  | BALTIMORE   |   |   |                               |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |                               |
| TOWSON 4   |  | ST. JOSEPH HOSPITAL   |       | Housewife   |  |   |   |   |                               |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  | 13b. COUNTY   |       | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                          |                               |
| MARYLAND   |  |   |       | BALTIMORE   |  |   |   | 3806 BIDDISON LANE #6                           |                               |
| 14. FATHER'S NAME  |  |   | First | Middle  | Last   | 15. MOTHER'S MAIDEN NAME First Middle Last  |   |   |                               |
| Israel Townsend  |  |   |       |   |  | Hettie Dirkson  |   |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |       | 17. INFORMANT   |  | Address   |   |   |                               |
| No   |  | 212-22-7668   |       | Mr. John W. Mitchell  |  | 3806 Biddison Lane  |   |   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive myocardial infarction, recent</u><br><u>1890</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Extensive metastatic carcinoma of kidney</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |       |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>180X</u>   |  |   |       |   |  |   |   |   |                               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |       |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |                               |
| 22a. I certify that (this hospital) attended the deceased from <u>July 29, 1968</u> to <u>August 3, 1968</u> , that (I) <u>last</u><br>saw the deceased alive on <u>August 3, 1968</u> , and that in (my <u>own</u> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) <u>did</u> (did not) <u>view</u> the body after death.  |  |   |       |   |  |   |   |   |                               |
| 22b. SIGNATURE <u>Christina Feliciano, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |       | 22c. DATE SIGNED<br>AUGUST 3, 1968  |  |   |   |   |                               |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>Christina Feliciano, M.D.</u>   |  |   |       | 22e. ADDRESS<br>7620 York Road, Towson 4, Maryland  |  |   |   |   |                               |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |   |                               |
| Burial   |  | 8/6/68  |       | Bowen Cemetery (M.E. Church)  |  | Berlin, Md.   |   |   |                               |
| 24. FUNERAL DIRECTOR<br><u>John A. Moran, Inc. 3000 E. Baltimore St.</u>   |  |   |       | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 6 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |   |                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11192

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Howard Mitchell</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>9</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>9:30 P.M.</b>   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>Dec 23, 1879</b>   |  | 6. AGE (In years last birthday)<br><b>88</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>House-In-Pines Conv. Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Telegrapher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>P. G.</b>  |  | 13c. CITY OR TOWN<br><b>Laurel</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>Francis Mitchell</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Sarah Jane Robey</b>  |  | 13e. STREET AND NUMBER<br><b>704 Gorman Ave</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-7972</b>   |  | 17. INFORMANT<br><b>Mrs Rose Romero Raven Blvd</b>  |  | Address <b>8405 Loch Ball m</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>174X</b> IMMEDIATE CAUSE (a) <b>Metastatic of Ribox Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of R.T. nipple.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 yr</b><br>Approximate interval between onset and death <b>8 mo.</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>170X</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-8-</b> , 19 <b>68</b> , to <b>8-9-</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8-9-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Wilmer K. Gallagher M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>8-10-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>6209 Frederick Ave, Baltimore, 28, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>8-12-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lux Hill Cem</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Laurel Maryland</b>                      |  |
| 24. FUNERAL DIRECTOR<br><b>Harold Dean Funeral Home</b>  |  | ADDRESS<br><b>Laurel Md</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 14 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Yuzgan</b>  |  |

UNITED STATES OF AMERICA

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11185

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11193

|   |                         |   |   |   |   |   |   |   |  |  |
|---|-------------------------|---|---|---|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>John Gordon Mitchell Jr.</i>   |                         |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Aug.</i> Day <i>18,</i> Year <i>1968</i> |   |   | 2b. HOUR <i>1 P.</i> M.   |   |   |  |  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br><i>April 4, 1941</i>  | 6. AGE (In years Age birthday) <i>27</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  | 2c. DATE PRONOUNCED DEAD<br>Month <i>August</i> Day <i>18,</i> Year <i>1968</i>                 |   |   | 2d. HOUR<br><i>1 P.</i> M.                         |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Nicodemus Road</i>       |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Electronic Technician</i>          |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |                         | 13b. COUNTY <i>BALTO</i>  |   | 13c. CITY OR TOWN<br><i>Balto. 34</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>8635 Rock Oak Road</i> |  |  |
| 14. FATHER'S NAME<br><i>John G. Mitchell Jr.</i>  |                         |   | 15. MOTHER'S MAIDEN NAME<br><i>Virginia Doughty</i>   |   |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, do, or unknown) <i>Yes</i>  |                         |   | 16b. SOCIAL SECURITY NO.<br><i>1159-1965</i>  |   | 17. INFORMANT<br><i>Mrs Virginia Mitchell</i> ADDRESS<br><i>941 N. Calvert St. Balt</i>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Drowning</i><br><i>9100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2hr 45 min</i>                            |                         |   |   |   |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>9298</i>   |                         |   |   |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         |   | 21b. TIME OF INJURY Month, Day, Year<br><i>10:15 AM Aug. 18, 68</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>Deceased drowned in Liberty Reservoir</i> |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>Deer Park Rd. Bridge</i> |   |   | 21f. LOCATION Street or R.F.D. No.<br><i>Nicodemus Rd.</i>  |   | 21f. LOCATION City or Town<br><i>Reisterstown</i> County<br><i>Balto.</i> State<br><i>Md.</i> |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><i>D. D. Caples</i>   |                         |   | M.D.<br><i>D. D. Caples, M. D.</i>  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED<br><i>8-20-68</i>                  |  |  |
| EXAMINER'S NAME (Type)<br><i>D. D. Caples, M. D.</i>  |                         |   | 6 Hanover Rd., Reisterstown, Md.  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |   | ADDRESS (Street, city, town, or county)             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 23b. DATE<br><i>Aug. 21, 1968</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park</i>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>                        |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>William E. Johnson</i>   |                         |   |   | ADDRESS<br><i>8521 Lockraven Blvd.</i>  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>AUG 22 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |

2311



828-2121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
|---|--|--|--|---|--|--|--|--|---------------------|-----------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
| Items 7, 8, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
| 11186   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
| 11194   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>CHARLES HARRISON MOFFETT  |  |  |  |   |  | 2a. DATE OF DEATH<br>8 Month 14 Day 68 Year  |  |  | 2b. HOUR<br>1:40 PM |                                   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)<br>79 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                     | IF UNDER 24 HRS.<br>HOURS MIN     |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore, Md.   |  |  |                     |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                     |                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>623 York Road  |                     |                                   |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |  |  |  |                     |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address  |  |  |                     |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221 |  |  |  |   |  |  |  |  |                     |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes            |                     |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                     |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |                     |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 14</u> , 19 <u>68</u> , to <u>Aug. 14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |                     |                                   |  |  |  |
| 22b. SIGNATURE<br><u>Rudiger Breitenecker</u>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS.  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                     | 22c. DATE SIGNED<br>Aug. 15, 1968 |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Rudiger Breitenecker, M.D.  |  |  |  |   |  | 22e. ADDRESS<br>Greater Baltimore Medical Center 21204                               |  |  |                     |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>8/17/1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Frederick, Maryland                 |  |  |                     |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Md.</u>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 21 1968</u>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |                     |                                   |  |  |  |

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2411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |   |   |   |   |   |
|--|--|--|---|--|---|---|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |   |   |   |   |   |
| CERTIFICATE OF DEATH   |  |  |   |  |   |   |   |   |   |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Harvey</b>   |  |  | First Middle Last<br><b>H. Money</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>August 2, 1968</b>  |   |   | 8:35 a. M.  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>Aug. 12, 1892</b>   |   | 6. AGE (In years last birthday)<br><b>75</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>government worker</b>             |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Marlow Hgts.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>6018 - 23rd Place.</b> |
| 14. FATHER'S NAME First Middle Last<br><b>Emmett Money</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sila</b>  |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>246-22-0488</b>  |  | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>              |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of left lung</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>163x</b><br><b>Bronchopneumonia</b> |  |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |   |   |
| 22a. I certify that <del>we</del> (this hospital) attended the deceased from <b>May 5</b> , 19 <b>67</b> , to <b>Aug. 2</b> , 19 <b>68</b> , that <del>we</del> (we) last saw the deceased alive on <b>Aug. 2</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.  |  |  |   |  |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Diomidis Pirovolidis</b>  |  |  |   | DEGREE<br><b>DEGREE</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-2-68</b>                       |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Diomidis Pirovolidis, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-4-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cranberry Church Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Ronda, North Carolina</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  |  |   | ADDRESS<br><b>21229</b>  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 6 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>      |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |   |   |  |  |  |
|---|--|---|--|--|---|---|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>11188</span> <span>CERTIFICATE OF DEATH</span> <span>11196</span> </div>   |  |   |  |  |   |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>James Walter Moore</b>  |  |   |  |  | 2a. DATE OF DEATH<br>Month <u>Aug</u> Day <u>21</u> Year <u>1968</u>  |   |   | 2b. HOUR <u>M</u>                                  |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH <b>Aug. 21, 1884</b>  |   | 6. AGE (In years last birthday) <b>83</b> YRS.  |   | 7. UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>salesman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <u>  </u>        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  |   | 13b. COUNTY <u>  </u>  |  | 13c. CITY OR TOWN <b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>201 S. Wickham Rd.</b>                             |  |
| 14. FATHER'S NAME First <u>James W.</u> Middle <u>Moore</u> Last <u>Moore</u>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME First <u>Rose Ann</u> Middle <u>Davis</u> Last <u>Davis</u>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>  |  |   | 16b. SOCIAL SECURITY NO. <b>212-03-9380A</b>   |  | 17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>4129</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ascu</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>   |  |   |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>weeks</u><br><u>years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4221</u>  |  |   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>  </u> <u>  </u> <u>19</u> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 14</u> , 19 <u>68</u> , to <u>Aug 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE <u>W. A. DEAR, JR.</u> DEGREE <u>MD.</u>   |  |   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED <u>17 Aug 68</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>W. A. DEAR, JR. MD.</u>   |  |   |  |  | 22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <u>8-20-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Lake View</u>  |   | 23d. LOCATION (City or Town) (County) (State) <u>Catonsville County Md.</u>                             |   |  |  |  |
| 24. FUNERAL DIRECTOR <u>Charles H. Midway</u> ADDRESS <u>2101 Frederick Ave</u>   |  |   |  |  | 25a. REC'D BY REGISTRAR <u>AUG 19 1968</u> DATE   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please copy carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11189   |  |  |                              |  |  |  |  |  |                                 | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                 |  |  |  |  |  |  |  | 11197                      |  |  |  |  |  |  |  |  |  |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|--|--|-----------------|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |                              |  |  |  |  |  |                                 | 2a. DATE OF DEATH  |  |                 |  |  |  |  |  |  |  | 2b. HOUR                   |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>MERVIN JOHNSTON MORGAN   |  |  |                              |  |  |  |  |  |                                 | Month Day Year<br>AUGUST 4 1968  |  |                 |  |  |  |  |  |  |  | 1:55A.M.                   |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  | 4. RACE                      |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday) |  |  | IF UNDER 1 YEAR |  |  | IF UNDER 24 HRS.   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| M   |  |  | W.                           |  |  | 6-1-15   |  |  | 53 YRS.                         |  |  | MONTHS DAYS     |  |  | HOURS MIN.   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH              |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Md.   |  |  | U.S.A.                       |  |  |  |  |  | Baltimore County Md.            |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Mt. Wilson  |  |  |                              |  | Mt. Wilson State Hospital  |  |  |  |                                 | MECHANIC   |  |                 |  |  | Civil Service  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |                              |  | 13b. COUNTY  |  |  |  |                                 | 13c. CITY OR TOWN  |  |                 |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER     |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |                              |  | CECIL  |  |  |  |                                 | NORTHEAST  |  |                 |  |  | YES  |  |  |  |  | 15E. THOMAS AVE.           |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |                                 |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>FRANK MORGAN   |  |  |                              |  | First Middle Last<br>MABEL HOPPER  |  |  |  |                                 |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |  |  |                                 | 17. INFORMANT Address  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |  |                              |  | 222-05-0086  |  |  |  |                                 | Records, Mt. Wilson State Hospital   |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |                              |  |  |  |  |  |                                 |  |  |                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA</u><br>492X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |                              |  |  |  |  |  |                                 |  |  |                 |  |  | YEARS  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>5271  |  |  |                              |  |  |  |  |  |                                 |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                 |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 27</u> , 19 <u>67</u> , to <u>AUGUST 4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                              |  |  |  |  |  |                                 |  |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>W. Newcomer</u>   |  |  |                              |  |  |  |  |  |                                 | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |                 |  |  | 22c. DATE SIGNED <u>8-4-68</u>   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.   |  |  |                              |  |  |  |  |  |                                 | 22e. ADDRESS Mount Wilson State Hospital   |  |                 |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |                              |  | 23b. DATE  |  |  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |                 |  |  | 23d. LOCATION (City or Town) (County), (State)   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |                              |  | 8-7-68   |  |  |  |                                 | North East Meth  |  |                 |  |  | North East Cecil Md.   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>Paul G. Grouch</u>  |  |  |                              |  |  |  |  |  |                                 | ADDRESS <u>Box 21</u>  |  |                 |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| Grant Funeral Home  |  |  |                              |  |  |  |  |  |                                 | North East Md.   |  |                 |  |  | DATE <u>AUG 6 1968</u>   |  |  |  |  | <u>Charles Judge</u>       |  |  |  |  |  |  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11198

|   |                  |   |   |  |  |  |  |   |
|---|------------------|---|---|--|--|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>Elizabeth Marie Morris</b>   |                  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>27</b> Year <b>1968</b> |  |  | 2b. HOUR <b>9A</b> M   |  |   |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>June 19, 1913</b>   | 6. AGE (In years last birthday) <b>55</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br>Month <b></b> Day <b></b> Year <b>19</b> M                       |  |   |
| 7a. BIRTHPLACE (State or foreign country) <b>Md.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BAITMORE</b> Md.   |  |   |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>104 MORRICK AVE</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                  | 13b. COUNTY <b>BAIT.</b>  |   | 13c. CITY OR TOWN <b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>104 MORRICK AVE</b>   |
| 14. FATHER'S NAME First <b>John</b> Middle <b>FORAKER</b> Last <b></b>  |                  |   | 15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>E.</b> Last <b></b>                                    |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                  | 16b. SOCIAL SECURITY NO. <b>222-01-8308</b>   |   | 17. INFORMANT <b>Leslie Morris</b>   |  | ADDRESS <b>104 MORRICK AVE</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Alcohol Heart Disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Alcohol abuse Secondary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs?</b> |                  |   |   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b> <b>Early Secondary Chronic Brain Syndrome</b>   |                  |   |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M. <b></b>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>         |                  |   |   |  |  |  |  |   |
| ACTUAL SIGNATURE <b>J. Nelson McKay</b>   |                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED <b>Aug 28, 1968</b>   |  |   |
| EXAMINER'S NAME (Type) <b>J. Nelson McKay</b>   |                  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |   |
|   |                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |  |   |
|   |                  |   | ADDRESS (Street, city, town, or county)   |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>8/30/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Violet Trille Md.</b>                       |  |   |
| 24. FUNERAL DIRECTOR <b>E.S. Mac Nab</b>  |                  |   |   | ADDRESS <b>301 Trebleck Rd #28 Balt Md</b>   |  | 25a. REC'D BY REGISTRAR <b>AUG 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
|--|--|--|--|---|--|---|---------------------------------|--|-----------------------------------|---|--------------------------------|-----|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |                                 |  | 2b. HOUR a.m. p.m.                |   |                                |     |  |  |
| Peter  |  |  | Morse #4148  |   |  | Aug. 31 '68   |                                 |  | 12:40                             |   |                                |     |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |   | IF UNDER 24 HRS.<br>HOURS MIN. |     |  |  |
| Male   |  | White  |  | 2-22-43   |  |   | 25 YRS.                         |  |                                   |   |                                |     |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH                |   |                                | Md. |  |  |
| Mississippi  |  |  | USA  |   |  |   |                                 |  | Baltimore                         |   |                                |     |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                                |     |  |  |
| Owings Mills   |  |  | Rosewood   |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER  |                                |     |  |  |
| Maryland 21617   |  |  | Queen Anne's   |   |  | Centreville   |                                 |  |                                   |   |                                |     |  |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| Edward Fleet Morse   |  |  | Barbara Brawner  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT   |                                 |  | Address                           |   |                                |     |  |  |
|  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>3960 Congestive Heart Failure, Death</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Rheumatic Heart Disease</u><br>(b) <u>15 yrs.</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Mitral, Aortic + Pulmonary insufficiency</u><br>(c) <u>15 yrs.</u> |  |  |  |   |  |   |                                 |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days, 15 yrs.</u> |                                |     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>410 x M. crocytic Hypochromic Anemia Sver Hgb 6 Gm</u>  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |                                   |   |                                |     |  |  |
|  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |                                 |  |                                   |   |                                |     |  |  |
|  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |                                 | County   |                                   | State   |                                |     |  |  |
|  |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) did (did not) view the body after death.   |  |  |  |   |  |   |                                 |  |                                   |   |                                |     |  |  |
| 22b. SIGNATURE<br><u>Richard A. Jones MD</u>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS.   |                                 | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |                                   | 22c. DATE SIGNED<br><u>2 Sept 68</u>                                    |                                |     |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Richard A. Jones   |  |  |  |   |  | 22e. ADDRESS<br>Carroll County General Hospital   |                                 |  |                                   |   |                                |     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |                                 |  |                                   |   |                                |     |  |  |
| Cremation  |  | 9/3/1968   |  | GREENMOUNT  |  | BALTIMORE, Md   |                                 |  |                                   |   |                                |     |  |  |
| 24. FUNERAL DIRECTOR<br><u>W. Brooks Bradley, M.D.</u>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 4 1968  |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |                                   |   |                                |     |  |  |

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Handwritten notes in cursive script, mostly illegible due to fading. The text appears to be organized into several lines or paragraphs within a rectangular frame.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

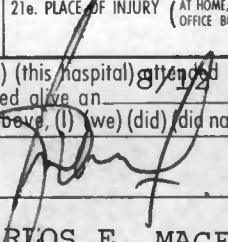
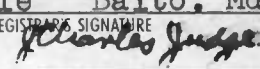
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11192

CERTIFICATE OF DEATH

11200

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARGARET DORIS MULLIKIN</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>12</b> Year <b>68</b>   |   |  | 2b. HOUR<br><b>7:50</b> pm  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>6-12-1913</b>  |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE MD.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Civil Service</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov. t.</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto. 12</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET AND NUMBER<br><b>6634 Loch Hill Rd.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Arthur E. Roden</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Leona Wortman</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-2708</b>  |  | 17. INFORMANT Address<br><b>Mrs. Patricia Walton 221 Brandon Rd</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1829</b> DUE TO, OR AS A CONSEQUENCE OF<br>DISSEMINATED CARCINOMATISIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>ADENOCARCINOMA OF UTERUS<br>(c) |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><b>174X</b>   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> , 19 <b>68</b> , to <b>8/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br><b>CARLOS E. MACFARLANE m.d.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>8/12/68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CARLOS E. MACFARLANE m.d.</b>   |  | 22e. ADDRESS<br><b>GBMC</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-15-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Balto. Md.</b>                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |  | ADDRESS<br><b>4905 York Rd., Balto.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 13 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |

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OFFICE OF THE

UNITED STATES DEPARTMENT OF JUSTICE

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11201

|   |                                   |  |   |  |
|---|-----------------------------------|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>JOHN WESLEY MUMMA</b>  |                                   | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>25</b> Year <b>1968</b> |   | 2b. HOUR<br><b>9:52 P.M.</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>           | 5. DATE OF BIRTH<br><b>Aug. 5, 1893</b>  | 6. AGE (In years last birthday)<br><b>75</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |                                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GRMC</b>                                |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Foreman-ret.</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |                                   | 13b. COUNTY <b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |
| 14. FATHER'S NAME First <b>George</b> Middle <b>Mumma</b> Last <b>Mumma</b>   |                                   | 15. MOTHER'S MAIDEN NAME First <b>Josephine</b> Middle <b>Patch</b> Last <b>Patch</b>                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                   | 16b. SOCIAL SECURITY NO.<br><b>215-01-8292</b>   |   | 17. INFORMANT<br><b>Family records</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                                   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>331X</b>   |                                   |  |   |  |
| 19a. DATE OF OPERATION  |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                                   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                   |  |   |  |
| ACTUAL SIGNATURE<br><b>William A. Pilisbury</b>   |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><b>8-25-68</b>   |
| EXAMINER'S NAME (Type)<br><b>William A. Pilisbury</b>   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | ADDRESS (Street, city, town, or county)<br><b>Pikesville, Md.</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Aug. 29, 1968</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Md.</b>  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Md.</b>  |                                   | 25a. DATE BY REGISTRAR<br><b>Aug 27 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Burns' Sons</b>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11194  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11202  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sparks</i><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rocky Hill Road</i>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>Baltimore</i><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sparks</i><br>d. STREET ADDRESS <i>Rocky Hill Road</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Anna</i> Middle <i>Maude</i> Last <i>Muringer</i>   |  | 4. DATE OF DEATH<br>Month <i>August</i> Day <i>4</i> Year <i>1968</i>   |  |
| 5. SEX <i>Female</i><br>6. COLOR OR RACE <i>White</i><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <i>July 19, 1887</i><br>9. AGE (in years last birthday) <i>81</i> yrs.<br>IF UNDER 1 YEAR: Months <i>8</i> Days <i>19</i><br>IF UNDER 24 HRS: Hours <i>19</i> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i><br>10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i><br>11. BIRTHPLACE (County & State, or foreign country) <i>Canada</i><br>12. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |  |   |  |
| 13. FATHER'S NAME <i>Walter Frederick Lawrence</i><br>14. MOTHER'S MAIDEN NAME <i>Mary Emma Squires</i>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i><br>(If yes give war or dates of service) <i>None</i><br>16. SOCIAL SECURITY NO. <i>None</i><br>17. INFORMANT <i>Family records</i><br>Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <i>Myocardial Infarction</i><br>DUE TO (c) <i>Vascular atherosclerosis</i><br>5 yrs |  | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>4201   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m.  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1-1-1945</i> to <i>8-4-1968</i> , that (I) (we) last saw the deceased alive on <i>8-4-1968</i> , and that death occurred at <i>7:15</i> M, from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <i>James G. Saffell</i><br>22c. PHYSICIAN'S NAME (Type) <i>James G. Saffell</i>  |  | 22b. DATE SIGNED <i>8-5-68</i><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <i>Reisterstown, Md</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i><br>23b. DATE THEREOF <i>Aug. 7, 1968</i><br>23c. NAME OF CEMETERY OR CREMATORY <i>Bosley Methodist Cemetery</i><br>23d. LOCATION (City, town or county) (State) <i>Sparks, Maryland</i>   |  | 24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i><br>25a. REC'D BY REGISTRAR <i>AUG 7 1968</i><br>25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |       |   |  |  |  |                                |
|---|--|--|-------|---|--|--|--|--------------------------------|
| 11195   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |       |   |  | 11203  |  |                                |
| CERTIFICATE OF DEATH  |  |  |       |   |  |  |  |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR                       |
| James   |  |  | E.    |   | Murphy   | AUG. 18 68   |  | M                              |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |
| Male  |  | white  |       | June 1, 1909  |  | 59 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.                            |
| Ireland   |  |  |       |   |  | Baltimore County   |  |                                |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |
| Catonsville   |  | Spring Grove State Hospital  |       | MAINTENANCE   |  | STEEL  |  |                                |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE   |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |
| Maryland  |  | Baltimore  |       | DUNDALK   |  |  |  | 3007 Dunleer Road              |
| 14. FATHER'S NAME   |  |  | First | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |                                |
| (dec'd) James   |  |  |       |   |  | (dec'd) Mary   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | (If yes give war or dates of service)  |       | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address  |  |                                |
|   |  |  |       |   |  | Records: Spring Grove State Hospital   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <del>486x</del> <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>493x</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Week</u> |  |  |       |   |  |  |  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic brain syndrome</u>  |  |  |       |   |  |  |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |
|   |  |  |       |   |  |  |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                                |
|   |  |  |       |   |  |  |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |       | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State                   |
|   |  |  |       |   |  |  |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 29</u> , 19 <u>67</u> , to <u>Aug. 18</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8-18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |       |   |  |  |  |                                |
| 22b. SIGNATURE<br><u>W. A. DEAR</u>   |  |  |       |   |  | 22c. DATE SIGNED<br><u>18 Aug 68</u>   |  |                                |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |       |   |  | 22e. ADDRESS   |  |                                |
| <u>W. A. DEAR JR MD</u>   |  |  |       |   |  | <u>SPRING GROVE STATE HOSPITAL</u>   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                |
| <u>BURIAL</u>   |  | <u>8-21-68</u>   |       | <u>SACRED HEART</u>   |  | <u>BALTO. Co. MD.</u>  |  |                                |
| 24. FUNERAL DIRECTOR  |  |  |       | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTERED SIGNATURE  |  |                                |
| <u>ULLRICH FUNERAL HOME, DUNDALK, MD.</u>   |  |  |       | <u>AUG 23 1968</u>  |  | <u>J. Charles Judge</u>  |  |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |   |  |  |  |                   |
|---|--|---|--|---|---|---|--|--|--|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |   |  |  |  |                   |
| 11196   |  |   |  |   |   |   |  |  |  |                   |
| 11204   |  |   |  |   |   |   |  |  |  |                   |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  |                   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br>Anna M. Netro   |   |   | Middle<br>Lost  |  | 2a. DATE OF DEATH<br>Aug. Month 20, day 68, or |  | 2b. HOUR<br>5 a M |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Aug. 16, 1923   |   |   | 6. AGE (In years<br>lost birthday)<br>45 YRS.                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Balto. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Balto.  |  | Md.  |  |                   |
| 10. CITY OR TOWN OF DEATH<br>Hampstead  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rd 2 |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Meat Packer |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Esskay |  |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Hampstead  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 13e. STREET AND NUMBER<br>Rd. 2                |  |                   |
| 14. FATHER'S NAME<br>First Middle Last<br>Henry Telljohann  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Busse |   |   |   |  |  |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>219-10-8289        |  | 17. INFORMANT<br>Address<br>Henry Netro Rd. 2 Hampstead, Md.  |   |   |  |  |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>4120<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive C-V Disease</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 min<br>2 yrs |  |   |  |   |   |   |  |  |  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>443x Obesity   |  |   |  |   |   |   |  |  |  |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?    |  |  |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                              |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)         |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County   |  | State             |
| 22a. I certify that (I) (this hospital) attended the deceased from July 7, 1967, to Aug 20, 1968, that (I) (we) last<br>saw the deceased alive on Aug 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |                   |
| 22b. SIGNATURE<br>M.C. Porterfield  |  |   |  | DEGREE<br>ATTENDING<br>PHYS.  |   | <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>8-21-68                    |  |                   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>M. C. Porterfield, M.D.  |  |   |  | 22e. ADDRESS<br>Hampstead, Md.  |   |   |  |  |  |                   |
| 23a. BURIAL, CREMATION,<br>or other (Specify)<br>Burial   |  | 23b. DATE<br>Aug. 22, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hampstead Cemetery  |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Hampstead Carroll CO. Md. |  |  |                   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Tipton - Eline Funeral Home Hampstead, Md.   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 23 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |                   |

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1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

Jerry Miller Rd. S. Haverhill, MA.

682-01-013

Автоматический переводчик с русского на английский язык

• • •

11197

CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LAWRENCE S. NIXON</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>8</b> Year <b>68</b>           |   |  | 2b. HOUR<br><b>4:00 A. M.</b>  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>6/11/1898</b>  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.                                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CATON RIDGE NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>218 S. Smallwood St. 21223</b>                        |  |
| 14. FATHER'S NAME First <b>STEWART</b> Middle <b>NIXON</b> Last <b>NIXON</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>Lucy</b> Middle <b>ABEL</b> Last <b>ABEL</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-4685</b>  |  | 17. INFORMANT Address<br><b>Mr. Earl L. Ekas, 3509 Forest Hill Rd. 21207</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5900</b><br><b>uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>6000</b><br>(b) <b>chronic Pyelonephritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>Years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Old CVA and Hemiplegia - BPH + urinary Retention</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-2-1967</b> , to <b>8-28, 1968</b> , that (I) (we) last saw the deceased alive on <b>8-28-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cesar V. Cavero</b>   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>8-30-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Cesar V. Cavero</b>   |  |   |  | 22e. ADDRESS<br><b>8629 Liberty Road, Randallstown, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-31-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore County, Maryland</b> |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

IN SENATE  
JANUARY 11, 1902  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899  
ALBANY  
ANDREW D. DOWD, STATE PRINTER  
1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |   |  |  |  |                                  |  |
|--|--|---|--|---|--|---|--|--|--|----------------------------------|--|
| 11193  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                       |  |   |  | 11206   |  |  |  |                                  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |                                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>Joseph</b>  |  | Middle<br><b>Oleszczuk</b>  |  | Last<br><b>Oleszczuk</b>  |  | 2a. DATE OF DEATH<br>Month<br><b>August</b> Day<br><b>18</b> Year<br><b>1968</b> |  | 2b. HOUR<br><b>6:45</b> M        |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>January 6, 1895</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Poland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>103 Lyndale Ave. #21236</b>                         |  |                                  |  |
| 14. FATHER'S NAME First Middle Last<br><b>UNKNOWN (DECEASED)</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>UNKNOWN (DECEASED)</b>   |  |   |  |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-3270</b>  |  | 17. INFORMANT Address<br><b>MICHALINA OLESZCZUK 103 LYNDALE AVE</b>   |  |   |  |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |  |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>   |  |   |  |   |  |   |  |  |  |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |                                  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-17</b> , 19 <b>68</b> , to <b>8-18</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8-18</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |   |  |  |  |                                  |  |
| 22b. SIGNATURE<br><i>Beatriz P. Dizon M.D.</i> DEGREE  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8-18-68</b>  |  |  |  |                                  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Beatriz P. Dizon, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>7620 York Rd. #21204</b>   |  |   |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL Specify<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/21/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>DUNDALK MARYLAND</b>                        |  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br><b>JOHN M WEBER &amp; SONS INC. 401 s. cluster</b>   |  |   |  | ADDRESS<br><b>401 s. cluster</b>  |  | 25a. DATE OF REGISTRATION<br><b>AUG 19 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Judge</i>                              |  |                                  |  |

11266

STATE OF NEW YORK

11266

January 18, 1908

Albany

Joseph

To

January 6, 1908

White

also

Baltimore

U.S.A.

London

London

Dr. Joseph

London

January 18, 1908

Baltimore

London

London (London)

London (London)

January 18, 1908

Positive heart failure  
Cardiac failure

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

January 18, 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ <sup>send</sup> the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 11/68

11198

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11207

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. DECEASED-NAME (Type or print) <b>ESTHER</b> First Middle Last <b>J. PARKER</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>Aug</b> Day <b>4</b> Year <b>68</b> |   | 2b. HOUR <b>3:30</b> M <b>A</b>              |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>NEGRO</b>   |   | 5. DATE OF BIRTH<br><b>SEP 13, '06</b>  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 6. AGE (In years last birthday) <b>61</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| 10. CITY OR TOWN OF DEATH <b>RANDOLPHSTOWN</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTO county GEN</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  | 13b. COUNTY <b>BALTO</b>   |   | 13c. CITY OR TOWN <b>Calto</b>  |  |
| 14. FATHER'S NAME First <b>HENRY</b> Middle Last <b>JONES</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>ALVERTA</b> Middle Last <b>JONES</b>                               |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.                                  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address <b>Mr. James A. Parker 2417 Calverton Hgt.</b>                                 |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebral Thrombosis; ? Pneumonia</b>  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                       |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-25, 1968</b> , to <b>8-4, 1968</b> , that (I) (we) last saw the deceased alive on <b>8-4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |
| 22b. SIGNATURE <b>Gregorio E. Bearfai, MD</b> DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/>  |  |  |   | 22c. DATE SIGNED <b>8-4-68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |   | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>8-7-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Zion Baptist Ch. Cem.</b>                                       |  |
| 24. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens Street</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Lottsburg, Virginia</b>                             |   | 25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>   |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11200   |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 11208  |  |
|---|---|--|--|--|--|
| CERTIFICATE OF DEATH  |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <u>William P. Parks.</u>   |   |  | 2a. DATE OF DEATH <u>Aug. 4 - 1968</u>   |  | 2b. HOUR <u>3:55 P.</u> M.   |
| 3. SEX <u>Male</u>  | 4. RACE <u>White</u>  | 5. DATE OF BIRTH <u>2-18-1895</u>  |  | 6. AGE (In years last birthday) <u>73</u> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign country) <u>Chance, Md</u>   | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <u>Baltimore</u> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH <u>Parkallstown.</u>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Balto. Co. General</u>                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Carpenter</u>   | 12b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>  | 13b. COUNTY <u>Balto.</u>   | 13c. CITY OR TOWN <u>Rockdale</u>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <u>8006 Parks Ave</u>   |  |
| 14. FATHER'S NAME First <u>Parks</u> Middle <u>Parks</u> Last <u>Parks</u>  | 15. MOTHER'S MAIDEN NAME First <u>Eva.</u> Middle <u>-</u> Last <u>Jones</u>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>YES World War I</u>   | 16b. SOCIAL SECURITY NO. <u>217-07-3433A</u>  | 17. INFORMANT <u>Mrs. M. May Parks - 8006 Parks Ave</u> Address <u>8006 Parks Ave</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crowning thrombosis</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerosis</u> |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>10 days</u><br><u>2 1/2 wks.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>4201</u>  |   |  |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 16, 1932</u> , to <u>Aug 4, 1968</u> , that (I) (we) lost the deceased alive on <u>August 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |  |  |
| 22b. SIGNATURE <u>Edwin L. Pierpont, M.D.</u> DEGREE <u>M.D.</u>  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <u>8/5/68</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>   | 22e. ADDRESS <u>8204 LIBERTY RD - BALTO. 21207 Md</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE <u>8-7-68</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Moneland Memorial Park</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Md.</u>                                     |  |  |
| 24. FUNERAL DIRECTOR <u>Johning Byers - 8728 Liberty Road</u>   | ADDRESS <u>8728 Liberty Road</u>  |  | 25a. BY REGISTRAR <u>Aug 5 1968</u>  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |                   |   |   |   |  |   |                   |  |  |
|---|--|---|-------------------|---|---|---|--|---|-------------------|--|--|
| 11201   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                       |                   |   |   | 11209   |  |   |                   |  |  |
| CERTIFICATE OF DEATH  |  |   |                   |   |   |   |  |   |                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>HELEN E. PEDDICORD</b>  |  |   | First Middle Last |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>Aug 2 1968</b>  |  | 2b. HOUR<br><b>5:45</b> M                           |                   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |                   | 5. DATE OF BIRTH<br><b>May 10, 1891</b>   |   | 6. AGE (In years<br>lost birthday)<br><b>77</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |                   |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Shangri La Nursing Home</b> |                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>At Home</b>  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |                   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>17 S. Wickham Road</b> |                   |  |  |
| 14. FATHER'S NAME<br><b>Allen B. Carr</b>   |  |   | First Middle Last |   |   | 15. MOTHER'S MAIDEN NAME<br><b>Grace Patrick</b>  |  |   | First Middle Last |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-7351</b>  |                   | 17. INFORMANT<br><b>Edward S. Peddicord, 7 Smith Ave, Ellicott City, Md. 21043</b>  |   |   |  |   |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b><br><b>4319</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-24-68</b> |  |   |                   |   |   |   |  |   |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>331X</b>  |  |   |                   |   |   |   |  |   |                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |   |                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-31-57</b> , 19__, to <b>8-2-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>8-1-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                   |   |   |   |  |   |                   |  |  |
| 22b. SIGNATURE<br><b>Harry S. Gumbel</b>  |  | DEGREE<br><b>MD</b>   |                   | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |   | 22c. DATE SIGNED<br><b>8-2-68</b>   |  |   |                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>HARRY S. GUMBEL</b>  |  | 22e. ADDRESS<br><b>4605 EDMONDSON AVE (29)</b>  |                   |   |   |   |  |   |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 5, 1968</b>  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Ellicott City Howard Md</b>                 |  |   |                   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Higinbotham-Slack Funeral Home, Ellicott City</b>  |  |   |                   | ADDRESS<br><b>John R. Slack Md</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 5 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ <sup>attach</sup> the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |   |  |  |   |   |
|---|--|---|--|--|---|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |  |  |   |   |
| 11208 CERTIFICATE OF DEATH 11210  |  |   |  |  |   |  |  |   |   |
| 1. DECEASED-NAME (Type or print) <b>Thomas C. Pitcher</b>   |  |   |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>4</b> Year <b>1968</b>                 |  | 2b. HOUR <b>8:00 P M</b>   |   |   |
| 3. SEX <b>male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br><b>Sept 30, 1884</b>   |   | 6. AGE (In years lost birthday) <b>83</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |   |
| 7a. BIRTHPLACE (State or foreign country) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |   |   |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Duany Towson Nurs. Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ink'salem Printing</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>421 Homeland Ave</b>  |   |
| 14. FATHER'S NAME First <b>John</b> Middle <b>Pitcher</b> Last <b>Pitcher</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>Frances</b> Middle <b>Horseman</b> Last <b>Pitcher</b> |  |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>212-03-0666</b>   |  | 17. INFORMANT Address <b>MRS. LOUISE WAINWRIGHT (SAME)</b>   |   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMPHYSEMA OF LUNGS - SEVERE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>491X</b><br>(b) <b>CHRONIC BRONCHITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 YRS. ±</b><br><b>40 YRS ±</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5020 ACUTE URINARY INFECTION (OLD RECTO-VESECAL FISTULA)</b>   |  |   |  |  |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 18, 1967</b> , to <b>AUG. 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>AUG. 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |   |   |
| 22b. SIGNATURE <b>Robert W. Garis, M.D.</b>   |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |   | 22c. DATE SIGNED <b>8/5/68</b>   |  |   |   |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Robert W. Garis</b>   |  |   |  | 22e. ADDRESS <b>12 E. Eager St.</b>  |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>8/7/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Waters Memorial Cem. Mutual</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Calvert Co. Md</b>                          |  |   |   |
| 24a. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>  |  |   |  | ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>  |   | 25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |   |

11204

CHRONIC BRONCHITIS

EMPHYSEMA OF LUNGS - SEVERE  
CHRONIC BRONCHITIS

ACUTE URINARY INFECTION (AND RECTO-VESTIBULAR FISTULA)

X

Aug 3 '68

FEB 18 '67

Aug 4 '68

Robert W. Jones, M.D.

X

8/2/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11203

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11211

CERTIFICATE OF DEATH

|  |  |   |   |   |  |   |  |  |                     |   |  |
|--|--|---|---|---|--|---|--|--|---------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br>Elizabeth  | Middle<br>Marie   | Last<br>Pitts  | 2a. DATE OF DEATH<br>8 Month 10 Day 68 Year   |  |  | 2b. HOUR<br>11:40 M |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>Aug. 17, 1919   |  | 6. AGE (In years<br>last birthday)<br>48 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                 |                     | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |                     |   |  |
| 1d. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Great. Balt. Med. Cen. |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Clerk Typist  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |                     |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>omission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>603 New Jersey Ave   |                     |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Everett C Pitts  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Marie J Kammer |   |  |   |  |  |                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-14-3338   |   | 17. INFORMANT<br>Franklin A Pitts   |  | Address<br>Same   |  |  |                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Wide Spread Metastases</u><br><u>174X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Recurrent Carcinoma, Rt. Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |   |  |  |                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>170X</u>   |  |   |   |   |  |   |  |  |                     |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <u>yes</u> |  |                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                     |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                     |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 29</u> , 19 <u>68</u> , to <u>Aug. 10</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>Aug. 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |   |   |  |   |  |  |                     |   |  |
| 22b. SIGNATURE<br><u>R. R. Breitnecher</u>   |  |   |   | DEGREE<br>ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22c. DATE SIGNED<br>8-10-68                    |                     |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. R. BREITNECHER,   |  |   |   | 22e. ADDRESS<br>6701 N CHARLES ST   |  |   |  |  |                     |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>8/13/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |  |                     |   |  |
| 24. FUNERAL DIRECTOR<br>Leonard J Ruck Inc   |  |   |   | ADDRESS<br>Balto. Md  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 12 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge |                     |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |   |  |  |                   |  |  |
|---|--|---|---|---|--|---|--|--|-------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |   |  |  |                   |  |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |  |                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br><b>ANTHONY</b>                         |   |  | Middle<br><b>POLUMSKI</b>   |  |  | Last              |  |  |
| 2a. DATE OF DEATH   |  |   | Month<br><b>8</b>                               |   |  | Day<br><b>29</b>  |  |  | Year<br><b>68</b> |  |  |
| 2b. HOUR  |  |   | <b>1:40 P.M.</b>                                |   |  |   |  |  |                   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>11/14/15</b>   |  |   | 6. AGE (In years last birthday)<br><b>52</b> |  | 7. YRS.           |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b>   |  |  |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BAL FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LONGSHOREMAN</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIPPING</b>                 |                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1127 HULL STREET</b>                    |                   |  |  |
| 14. FATHER'S NAME   |  |   | First<br><b>JOSEPH</b>                          |   |  | Middle<br><b>POLUMSKI</b>   |  |  | Last              |  |  |
| 15. MOTHER'S MAIDEN NAME  |  |   | First<br><b>CATHERINE</b>                       |   |  | Middle<br><b>BURDINSKI</b>  |  |  | Last              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214 01 59 58</b> |   |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>                                 |  |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA, OROPHARYNX</b><br><b>1469</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b> |  |   |   |   |  |   |  |  |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>148X</b>   |  |   |   |   |  |   |  |  |                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ P.M. _____<br>Month _____ Day _____ Year _____<br><b>19</b>        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |  |  |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/12/68</b> , 19____, to <b>8/29/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/29/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |                   |  |  |
| 22b. SIGNATURE<br><b>Jose A. Raquel Jr. M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS.<br><input type="checkbox"/>   |  | MED. DIRECTOR<br><input type="checkbox"/>   |  | STAFF PHYS.<br><input checked="" type="checkbox"/>                   |                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOSE A. RAQUEL, M.D.</b>   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   | 22c. DATE SIGNED<br><b>8/29/68</b>  |  |   |  |  |                   |  |  |
| 23a. BURIAL, CREMATION, or other disposition<br><b>BURIAL</b>   |  | 23b. DATE<br><b>9-2-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>German Hill Rd. Balto. Md.</b>                            |  |  |                   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles L. Stevens Funeral Home, Inc. Balto. Md.</b>   |  | 1501 E. Fort Ave.   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 3 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |                   |  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

1911

REPORT OF THE UNITED STATES DEPARTMENT OF AGRICULTURE

ON THE PROGRESS OF THE AGRICULTURAL INDUSTRIES OF THE UNITED STATES

FOR THE YEAR 1910

BY THE UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

1911

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                                   |  |
|--|--|--|--|--|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle   | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR<br>M                     |  |
| CLARA BERTHA POPP  |  |  |  |  |  | AUGUST 16 1968  |  |                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| FEMALE   |  | WHITE  |  | AUG. 4, 1882   |  | 86 YRS.   |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| MARYLAND   |  | USA  |  |  |  | BALTO COUNTY  |  | Own Home                          |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                                   |  |
| TOWSON   |  |  | ST. JOSEPH'S HOSPITAL  |  |  | HOMEMAKER   |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER            |  |
| MARYLAND   |  |  | BALTO  |  |  |   |  | MANOR RD. PHOENIX, MD.            |  |
| 14. FATHER'S NAME  |  |  | First  | Middle   | Last   | 15. MOTHER'S MAIDEN NAME  |  | First                             | Middle Last                                  |
|  |  |  | Unknown  |  |  |   |  | Unknown                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  | Address                           |  |
| No   |  |  | None   |  |  | Family records  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, left.</u><br>4319 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |                                   |  |
| 331X   |  |  |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>AUG. 16</u> , 19 <u>68</u> , to <u>AUG. 16</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>AUGUST 16</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |
| 22b. SIGNATURE<br><u>Christine Feliciano, M.D.</u>   |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8-17-68       |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Christine Feliciano, M.D.  |  |  |  |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |
| Burial   |  | Aug. 19, 1968  |  | Providence Cemetery  |  | Providence, Balto. Co., Md.   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>John Burns & Sons 610-612 York Rd.   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 21 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |                                   |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |   |                                   |                  |
|--|--|--|--|--|---|--|---|-----------------------------------|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |   |                                   |                  |
| 11205 CHRISTINA 11214  |  |  |  |  |   |  |   |                                   |                  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |  |   |                                   |                  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |   | 2b. HOUR                          |                  |
| CHRISTINA  |  |  | XXX E. POTTER  |  |   | 8 Month 25 Day 68 Year   |   | 9 PM                              |                  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR MONTHS DAYS       |                  |
| F  |  | W  |  | 5-5-1884   |   | 84-YRS.  |   |                                   |                  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |                                   |                  |
| BALTO  |  | US   |  |  |   | BALTO Md.  |   |                                   |                  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |   | 12b. KIND OF BUSINESS OR INDUSTRY |                  |
| Catonsville  |  |  | SPANGH - LANH  |  |   |  |   |                                   |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER            |                  |
| MD   |  |  | Baltimore  |  |   |  |   | 5000 PENNA AVE                    |                  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |                                   |                  |
| Geo  |  |  | DOLLE  |  |   | IDA  |   |                                   |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT Address  |   |                                   |                  |
| NO   |  |  |  |  |   | KENNETH POTTER 3004 CLAYTON RD   |   |                                   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |   |                                   |                  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |   |                                   |                  |
| IMMEDIATE CAUSE (a) Cerebral artery thrombosis.  |  |  |  |  |   |  |   |                                   |                  |
| 4339 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |   |                                   |                  |
| (b) Cerebral atherosclerosis   |  |  |  |  |   |  |   |                                   |                  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |                                   |                  |
| (c) Cause unknown  |  |  |  |  |   |  |   |                                   |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |   |                                   |                  |
| 332X   |  |  |  |  |   |  |   |                                   |                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |                  |
|  |  |  |  |  |   |  |   |                                   |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                                   |                  |
|  |  |  |  |  |   |  |   |                                   |                  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |   |                                   |                  |
|  |  |  |  |  |   |  |   |                                   |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-7, 1967, to 8-25, 1968, that (I) (we) last saw the deceased alive on 7-12-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |                                   |                  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED |
| Dr. Cesar J. Pellerano   |  |  |  |  |   |  |   |                                   | 8-26-68          |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |  |   |                                   |                  |
| Dr. Cesar J. Pellerano   |  |  |  |  | 2436 Washington Blvd., Balto., Md.  |  |   |                                   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |   |                                   |                  |
| BURIAL   |  | 8-28-1968  |  | Glen Haven Cemetery  |   | Glen Burnie, Maryland  |   |                                   |                  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE  |                                   |                  |
| Howard H. Hubbard 4107 Wilkens Ave. 21229  |  |  |  |  | AUG 28 1968   |  | Charles Judge   |                                   |                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |   |   |  |   |
|--|--|---|---|---|--|---|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |   |   |  |   |
| 11207 CERTIFICATE OF DEATH 11215   |  |   |   |   |  |   |   |  |   |
| 1. DECEASED NAME<br>(Type or print) <b>Bessie</b>  |  |   | First <b>N.</b> Middle <b>Prestianni</b> Last                       |   |  | 2a. DATE OF DEATH<br>8 Month 26 Day 68 Year   |   |  | 2b. HOUR <b>4:32</b> P <b>M</b>                                 |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>August 14, 1891</b>  |  |   | 6. AGE (In years last birthday)<br><b>77</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A. Italy</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |   |
| 1d. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Housewife</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                        |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |   | 13e. STREET AND NUMBER<br><b>4103 Granite Ave. 21206</b> |   |
| 14. FATHER'S NAME<br>First <b>Philip</b> Middle <b>Bonsignore</b> Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Nancy</b> Middle <b>?</b> Last |   |  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>212-16-2415</b>  |   | 17. INFORMANT<br>Address <b>Nurzio J Prestianni 5915 Edna Ave</b>   |  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>2509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Diabetis Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>260x</b>   |  |   |   |   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |   |
| 22a. I certify that <b>AF</b> (this hospital) attended the deceased from <b>August 21, 19 68</b> , to <b>August 26, 19 68</b> , that <b>AF</b> (we) last saw the deceased alive on <b>August 26, 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(A)</b> (we) (did) <b>(XXXX)</b> view the body after death.   |  |   |   |   |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Camilo J. Tomboc</b>  |  |   |   | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-26-68</b>                       |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Camilo Tomboc, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>7620 York Rd. 21204</b>  |  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/30/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc Baltimore, Maryland</b>  |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 27 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>    |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11203

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11216

|  |  |  |                          |  |   |   |  |  |  |  |
|--|--|--|--------------------------|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>Harry</b>  | Middle<br><b>Francis</b> | Last<br><b>Rawlings</b>  | 2a. DATE OF DEATH<br>Month <b>Aug</b> Day <b>2</b> Year <b>1968</b>       |   | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |                          | 5. DATE OF BIRTH<br><b>March 6, 1906</b>   |   | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md. Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>South Rd., Pikesville</b> |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Building</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>W.H. Sands</b>  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |                          | 13c. CITY OR TOWN<br><b>Pikesville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>South Rd.</b> |  |  |
| 14. FATHER'S NAME<br>First <b>Harry</b> Middle <b>Francis</b> Last <b>Rawlings</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Helen</b> Middle <b>Tyson</b> Last <b>Pikesville</b>                    |                          | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service) <b>None</b>  |   |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>unknown</b> |  |
| 17. INFORMANT<br><b>Mrs. Betty Gregory Rawlings</b>  |  | Address<br><b>South Rd. Md.</b>  |                          | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |  |                          |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1, 1968</b> , to <b>Aug 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Vicente M. Ruido MD</b>   |  | DEGREE<br><b>MD</b>  |                          | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22c. DATE SIGNED<br><b>August 3-68</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>VICENTE M RUIDO</b>   |  | 22e. ADDRESS<br><b>Spring Grove State Hospital</b>   |                          |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug. 5, 1968</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Baltio. Md.</b>                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Frank H. Thurl</b>  |  | ADDRESS<br><b>Pikesville 8, Md.</b>  |                          | 25a. RECD BY REGISTRAR<br>DATE <b>AUG 6 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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**Figure 2.**

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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References

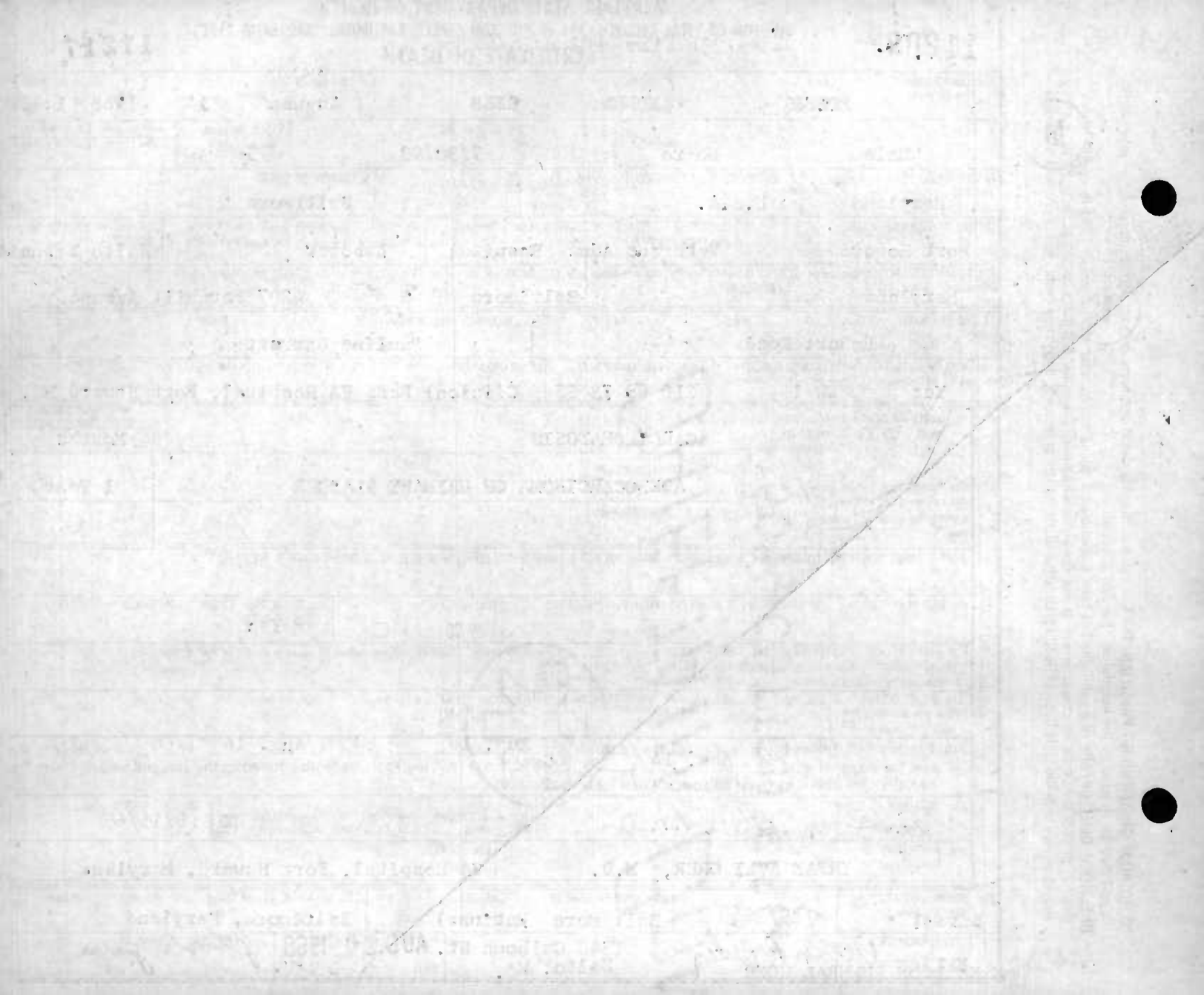
• *Journal of Management Education* 30(1): 10-12

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                   |   |  |  |  |  |                   |  |
|---|--|--|-------------------|---|--|--|--|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                   |   |  |  |  |  |                   |  |
| 11209   |  |  |                   |   |  |  |  |  |                   |  |
| 11217   |  |  |                   |   |  |  |  |  |                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |                   |  |
| ROBERT  |  |  | ANDREW            |   |  | August Month 14 Day 1968   |  | 1:10 M   |                   |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                   |  |
| Male  |  | Negro  |                   | 7/30/93   |  | 75 YRS.  |  |  |                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.  |                   |  |
| Maryland  |  | U.S.A.   |                   |   |  | Baltimore  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                   |  |
| Fort Howard   |  | Veterans Adm. Hospital   |                   | Laborer   |  | Balto Transit  |  |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                 |                   |  |
| Maryland  |  |  |                   | Baltimore   |  |  |  | 4207 Fernhill Avenue                                   |                   |  |
| 14. FATHER'S NAME   |  |  | First Middle Last |   |  | 15. MOTHER'S MAIDEN NAME   |  |  | First Middle Last |  |
| Robert  |  |  | Reed              |   |  | Pauline  |  |  | Garrett           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |  | Address  |  |  |                   |  |
| Yes   |  | WW-1   |                   | 216 09 73 95  |  | Clinical Rcds VA Hospital, Fort Howard Md.   |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>ADENOCARCINOMA OF URINARY BLADDER<br>1 Year<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ADENOCARCINOMA OF URINARY BLADDER</u><br>(c) <u>ADENOCARCINOMA OF URINARY BLADDER</u> |  |  |                   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>1810   |  |  |                   |   |  |  |  |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |  |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 10</u> , 19 <u>68</u> , to <u>Aug. 14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                   |   |  |  |  |  |                   |  |
| 22b. SIGNATURE<br><u>Irfan Avni Orer M.D.</u>   |  | 22c. DATE SIGNED<br>8/15/68  |                   | 22d. PHYSICIAN'S NAME (Type)<br>IRFAN AVNI ORER, M.D.   |  |  |  |  |                   |  |
| 22e. ADDRESS<br>VA Hospital, Fort Howard, Maryland  |  |  |                   |   |  |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>8/19/1968   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                         |  |  |                   |  |
| 24. FUNERAL DIRECTOR<br>KELSON FUNERAL HOME   |  | 24b. DATE<br>8/19/1968   |                   | 24c. ADDRESS<br>1348 Calhoun St. Balto. Md.   |  | 24d. DATE<br>Aug 20 1968   |  | 24e. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>       |                   |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11210

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11218

|  |         |  |  |   |      |   |     |  |   |  |                |
|--|---------|--|--|---|------|---|-----|--|---|--|----------------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |   |      | 2a. DATE KNOWN OF DEATH   |     |  | 2b. HOUR  |  |                |
| MORGAN R. REES   |         |  |  |   |      | Month Day Year  |     |  | Month Day Year  |  |                |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS   |     | 2c. DATE PRONOUNCED DEAD                                 |   |  | 2d. HOUR       |
| Male   | CAU     | April 15, 1901   | 67 YRS.  | MONTHS  | DAYS | HOURS   | MIN | Month Day Year   |   |  | Month Day Year |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |     |  | Md.   |  |                |
| Tenn.  |         | USA  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |      | Baltimore   |     |  |   |  |                |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                |
| Essex (21)   |         |  | 1 Mecca Lane   |   |      | Attendant   |     |  | Service Station   |  |                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  | 13b. COUNTY  |   |      | 13c. CITY OR TOWN   |     |  | 13d. INSIDE CITY LIMITS?  |  |                |
| Maryland   |         |  | Baltimore  |   |      | Essex (21)  |     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME   |   |      | 13e. STREET AND NUMBER  |     |  |   |  |                |
| First Middle Last  |         |  | First Middle Last  |   |      | 1 Mecca Lane  |     |  |   |  |                |
| Henry Rees   |         |  | Mary   |   |      |   |     |  |   |  |                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT   |     |  | ADDRESS   |  |                |
| No   |         |  | 235 10 3230A   |   |      | Winnie Rees   |     |  | Same  |  |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |      |   |     |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-Disease</u>  |         |  |  |   |      |   |     |  |   |  |                |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |      |   |     |  |   |  |                |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PULMONARY Emphysema</u>  |         |  |  |   |      |   |     |  |   |  |                |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |         |  |  |   |      |   |     |  |   |  |                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |  |   |      |   |     |  |   |  |                |
| 4221   |         |  |  |   |      |   |     |  |   |  |                |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |      |   |     | 20. AUTOPSY?   |   |  |                |
|  |         |  |  |   |      |   |     | YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |                |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |      |   |     |  |   |  |                |
|  |         | HOUR A.M. P.M.   |  |   |      |   |     |  |   |  |                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                          |      |   |     |  |   |  |                |
|  |         |  |  |   |      |   |     |  |   |  |                |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |      |   |     |  |   |  |                |
| ACTUAL SIGNATURE <u>M.B. Davis</u>   |         |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                       |      |   |     | 22b. DATE SIGNED <u>8/8/68</u>                           |   |  |                |
| EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md. 21222  |         |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                   |      |   |     |  |   |  |                |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |         |  |  |   |      |   |     |  |   |  |                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |      |   |     | 23d. LOCATION (City or Town) (County) (State)            |   |  |                |
| Burial   |         | 8/11/68  |  | Blue Ridge Memorial Gardens Prosperity, W. Va.  |      |   |     |  |   |  |                |
| 24. FUNERAL DIRECTOR <u>Bruzdzinski</u>  |         |  |  | 25a. REC'D BY REGISTRAR   |      |   |     | 25b. REGISTRAR'S SIGNATURE                               |   |  |                |
| Bruzdzinski Funeral Home 1407 Eastern Ave.   |         |  |  | DATE AUG 12 1968  |      |   |     | <u>Charles Judge</u>                                     |   |  |                |

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Katherine</b>   |  |  | First Middle Last<br><b>M. Reilly</b>                                   |   |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>2</b> Year <b>1968</b>   |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>June 8, 1883</b>   |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rodgers Forge</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>237 Rodgers Forge Rd.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Clerk retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Rodgers Forge</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>237 Rodgers Forge Rd.</b>                      |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Andrew Philip Reilly</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Rose Ann Mc Coy</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>705 03 7540</b>                      |   | 17. INFORMANT<br>Address<br><b>Miss Helen E. Reilly 237 Rodgers Forge Rd.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 Hrs.</b><br><b>25 yrs.</b> |  |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b>  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1949</b> , to <b>1968</b> , that (I) ( <del>we</del> ) lost<br>saw the deceased alive on <b>Feb</b> 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas J. Brennan M.D.</b>  |  |  |   | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Thomas J. Brennan M.D.</b>  |  |  |   | 22c. DATE SIGNED<br><b>3 August 1968</b>  |  |   |  |   |  |
| 22e. ADDRESS<br><b>2217 Harford Road Balto 14 Md</b>   |  |  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/6/1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Balto. Md.</b>                                  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell Wiedefeld Home 6520 York Rd.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11212

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11220

|   |                  |  |                                   |   |   |   |  |
|---|------------------|--|-----------------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First<br>Frances   | Middle<br>Elizabeth               | Last<br>Rice  | 20. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 8-2 1968 |   | 2b. HOUR<br>54. M                                      |
| 3. SEX<br>female  | 4. RACE<br>white | 5. DATE OF BIRTH<br>Jan 24, 1907   |                                   | 6. AGE (In years last birthday)<br>61 YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS<br>HOURS<br>MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Aug. Day 2 Year 1968 |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1925 Wareham Rd. |                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Machine Operator   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Products   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |                  | 13b. COUNTY Baltimore  |                                   | 13c. CITY OR TOWN<br>Dundalk  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>1925 Wareham Road   |                  |  |                                   |   |   |   |  |
| 14. FATHER'S NAME<br>Paul   |                  | First<br>Middle<br>Last  | 15. MOTHER'S MAIDEN NAME<br>Helen |   | First<br>Middle<br>Last   | 15. ADDRESS<br>Konopka  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>219-16-6107                 |                                   | 17. INFORMANT Son:<br>Joseph M. Rice  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 H-S-C-V-DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |                                   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221 Epilepsy   |                  |  |                                   |   |   |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                     |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                     |                                   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  | County State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |                                   |   |   |   |  |
| ACTUAL SIGNATURE<br>Melvin B. Davis M.D.  |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                   | 6800 Mornington Rd.   |   |   |  |
| EXAMINER'S NAME (Type)  |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                   | 22b. DATE SIGNED<br>Balt. Md. 21222   |   |   |  |
|   |                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                      |                                   | ADDRESS (Street, city, town, or county)   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>Aug. 5, 1968  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial  |   | 23d. LOCATION (City or Town) (County) (State)<br>Dorsey Howard Co. Md.                          |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, Dundalk, Maryland 21222   |                  |  |                                   | 25a. REC'D BY REGISTRAR<br>AUG 5 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

## 参考文献

2191

1968 5 20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach page 3 to the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |   |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br>Hilda   | Middle<br>A.  | Last<br>Rice   | 2a. DATE OF DEATH<br>Aug. Month 2 Day 1968  |  | 2b. HOUR<br>1:45 P.M.                             |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Aug. 9- 1906  |  | 6. AGE (In years<br>last birthday)<br>61 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |   |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) 1712 Woodland Rd. |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) Housewife  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.  |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1712 Woodland Dr. 21222 |   |
| 14. FATHER'S NAME First Middle Last<br>Charles E. Ketchum   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Anna Rose Huhn |   |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown NO  |  |   | 16b. SOCIAL SECURITY NO.<br>216-42-0534                      |   | 17. INFORMANT Address<br>Husband, Mr. George J. Rice Sr. #13-a,b,c,d,e.              |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF PANCREAS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>1579<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                  |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>12 WKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>157X   |  |   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1968</u> , to <u>8/11/68</u> 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>8/11/68</u> 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(did not)</del> view the body after death. |  |   |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><u>W E Baermann M.D.</u>  |  |   |  | 22c. DATE SIGNED<br><u>8/13/68</u>  |  |   |  |   |   |
| 22d. PHYSICIAN'S NAME (Type) W. E. Baermann M.D.  |  |   |  | 22e. ADDRESS<br>3401 Dundalk Ave. Dundalk, Md. 21222  |  |   |  |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br>Aug-5-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus   |  | 23d. LOCATION (City or Town) (County) (State)<br>Dundalk, Balto. Co. Md.                        |  |   |   |
| 24. FUNERAL DIRECTOR<br>John J. Duda, Dundalk, Maryland 21222   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 5 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |   |

1991

2191



[Faint, illegible text and markings throughout the page, including a large circular stamp on the right side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |                                |   |
|---|--|---|---|---|--|--|---|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |                                |   |
| 11214   |  |   |   |   |  |  |   |                                |   |
| 11222   |  |   |   |   |  |  |   |                                |   |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |                                |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month Day Year  |   |                                | 2b. HOUR<br>p. M.                               |
| Daniel  |  |   | V. Richardson   |   |  | August 27, 1968  |   |                                | 9:40 p.   |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| male  |  | white   |   | May 6, 1885   |  | 83 YRS.  |   |                                |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |                                | Md.   |
| Md.   |  | U. S.   |   |   |  | Baltimore  |   |                                |   |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |
| Catonsville   |  |   | SPRING GROVE STATE HOSP.  |   |  |  |   |                                |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 13e. STREET AND NUMBER         |   |
| Md.   |  | Pr. Geo.  |   | Hillside  |  |  |   | 5004 N. Street                 |   |
| 14. FATHER'S NAME<br>First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |   |  |  |   |                                |   |
| James   |  |   | Unknown   |   |  |  |   |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address   |  |   |                                |   |
| Yes, no, or unknown   |  |   | 578-01-0226A  |   | Records: SPRING GROVE STATE HOSPITAL   |  |   |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis, recent</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes and severe degenerative changes.</u>                                |  |   |   |   |  |  |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |   |   |   |  |  |   |                                |   |
| 4500  |  |   |   |   |  |  |   |                                |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |                                |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>April 26, 1968</u> , to <u>Aug. 27, 1968</u> , that (X) (we) last<br>saw the deceased alive on <u>Aug. 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |   |                                |   |
| 22b. SIGNATURE<br><u>Rafael H. Marin, M.D.</u>  |  |   |   |   | DEGREE<br>ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>8-28-68   |                                |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |   |   | 22e. ADDRESS   |  |   |                                |   |
| Rafael H. Marin, M.D.   |  |   |   |   | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228   |  |   |                                |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |                                |   |
| Burial  |  | 8/31/1968   |   | Cedar Hill  |  | Suitland Pk. Shores Md   |   |                                |   |
| 24. FUNERAL DIRECTOR<br><u>Wally G. Ly</u>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 30 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |                                |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11213

CERTIFICATE OF DEATH

11223

|   |  |  |   |   |  |  |  |  |   |       |
|---|--|--|---|---|--|--|--|--|---|-------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Ferdinand William Ritter, Jr.</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>AUG</b> Day <b>24</b> Year <b>1968</b>  |   |  | 2b. HOUR<br>M  |  |  |   |       |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>Dec. 14, 1877</b>  |  | 6. AGE (In years last birthday)<br><b>90</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS OAYS HOURS MIN           |   |       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |   |       |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>sheet metal worker</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1232 North Calvert St.</b>              |  |   |       |
| 14. FATHER'S NAME<br>First <b>Ferdinand W.</b> Middle <b>Ritter</b> Last <b>Sr.</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Wrenn</b> Middle <b></b> Last <b></b>                                      |   |  |  |  |  |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-1705</b>  |   | 17. INFORMANT<br>Address <b>Records: SPRING GROVE STATE HOSPITAL</b>                 |  |  |  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>486X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b><br><b>days</b> |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>493X</b>  |  |  |   |   |  |  |  |  |   |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County   |   | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 26</b> , 19 <b>67</b> , to <b>Aug-24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |   |   |  |  |  |  |   |       |
| 22b. SIGNATURE<br><b>Rolando Vieta</b>  |  |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>8-24-68</b>   |  |  |   |       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ROLANDO VIETA</b>  |  |  |   | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |  |  |  |   |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-27-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MARYLAND</b>   |  |  |   |       |
| 24. FUNERAL DIRECTOR<br><b>WEBER FUNERAL HOME</b>   |  |  |   | ADDRESS<br><b>5311 EDMONDSON AVE</b>  |  | 25a. REG'D BY REGISTRAR<br>DATE <b>AUG 26 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |       |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11216  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                               |  |  |  | 11224  |  |
|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>Thomas W. Robinson</b>   |  |   |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>12</b> Year <b>68</b>   |  | 2b. HOUR <b>3:40</b> P.M.  |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>  |  | 5. DATE OF BIRTH <b>10-21-94</b>   |  | 6. AGE (In years lost birthday) <b>73</b> YRS.                       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Balto. Garrison</b> Md.                        |  |
| 10. CITY OR TOWN OF DEATH <b>Garrison, Md.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Foxleigh Conv. Center</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md., Balto.</b>   |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET AND NUMBER <b>1601 Northwick Rd.</b>                     |  |
| 14. FATHER'S NAME First <b>Idell</b> Middle <b>H</b> Last <b>Robinson</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>Susanna</b> Middle <b>Parker</b> Last                                   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO. <b>212-12-6228</b>   |  | 17. INFORMANT <b>Mrs. Bertha Robinson</b>  |  | Address <b>Same as # 13c</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Astrocytoma, cerebral</b><br><b>191X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____     |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1939 Arteriosclerotic heart disease</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>2/68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Astrocytoma</b>                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/9</b> , 19 <b>66</b> , to <b>7/23</b> 19 <b>68</b> , that (I) <del>was</del> last saw the deceased alive on <b>7/23</b> 19 <b>68</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Louis H. Schaffer MD</b>   |  |   |  | 22c. DATE SIGNED <b>8/13/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Louis H. Schaffer, M.D.</b>  |  |   |  | 22e. ADDRESS <b>222 W. Cold Spring Lane. Balto., Md. 10</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>8/16/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Carroll Co, Md.</b> |  |
| 24. FUNERAL DIRECTOR <b>6212 Balt. Nat Pike Wm. Cook-Brooks West Inc Balt. Md. 21228</b>   |  |   |  | 25a. RECEIVED BY REGISTRAR <b>AUG 19 1968</b> 25b. REGISTRAR'S SIGNATURE <b>Johanna Judge</b>  |  |  |  |

John D. Ives

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |  |  |  |            |
|---|--|---|--|--|--|--|------------|
| 11217   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 11225  |            |
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle   | Lost   | 2a. DATE OF DEATH<br>Month Day Year                                  |  | 2b. HOUR   |
| ELSIE   |  |   |  | ROME   | AUGUST 9, 1968   |  | 3:40A.M.   |
| 3. SEX  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                       |            |
| FEMALE  | WHITE  |   | JUNE 21, 1895  |  | 73 YRS.  |  |            |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |            |
| ROCHESTER, N.Y.   | U.S.A.   |   |  | BALTIMORE Md.  |  |  |            |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |            |
|   | 24 WARREN PARK DR., APT. B4  |   | HOUSEWIFE  |  | AT HOME  |  |            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER   |  |  |            |
| MARYLAND  | BALTIMORE  |   |  | 24 WARREN PK. DR., APT. B-4  |  |  |            |
| 14. FATHER'S NAME   | First  | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME   | First  | Middle   | Lost       |
| GUSTAV  |  |   | ROTHHOLZ   | IDA  |  |  | FRIEDEBERG |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |  |  |            |
| NO  |  |   | MR. EUGENE ROME, 24 WARREN PK. DR., APT. B-4   |  |  |  |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u><br>1538 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Jun '67</u> |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1538</u>   |  |   |  |  |  |  |            |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |  |  |            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |  |  |            |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>67</u> , to <u>8-9-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-7-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |   |  |  |  |  |            |
| 22b. SIGNATURE<br><u>Joseph Deckelbaum</u>  |  | DEGREE  | ATTENDING PHYS. <input checked="" type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/>                               | STAFF PHYS. <input type="checkbox"/>                                 | 22c. DATE SIGNED<br><u>8-9-68</u>                              |            |
| 22d. PHYSICIAN'S NAME (Type)<br>JOSEPH DECKELBAUM   |  | 22e. ADDRESS<br>3502 W. ROGERS AVENUE   |  |  |  |  |            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   | 23b. DATE<br>8-11-68   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND |  |  |            |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 13 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |  |  |            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 18 Film 403 8-19-68 and  |  |  |  |  |  |  |  |  |  | MARYLAND DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201      |  |  |  |  |                             |  |  |  |  | 11226 |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| 11218   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 11226  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Anna Pricilla Sadler</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br><b>August 1 1968</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br><b>7 PM</b>  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  |  |  |  | 4. RACE<br><b>white</b>  |  |  |  |  | 5. DATE OF BIRTH<br><b>October 26, 1892</b>  |  |  |  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove State Hospital</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  |  |  | 13b. COUNTY<br><b>Harford County</b>   |  |  |  |  | 13c. CITY OR TOWN<br><b>Street</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br><b>Street, Maryland</b>                                |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>(dec'd) Henry Beason</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>(dec'd) Ida M. Lloyd</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-6485</b>   |  |  |  |  | 17. INFORMANT Address<br><b>Records: Spring Grove State Hospital</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>180x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of the cervix with generalized metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>171x</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1968</b> , to <b>August 1, 1968</b> , that (I) (we) lost saw the deceased alive on <b>August 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Vicente M. Pivano</b>  |  |  |  |  | 22c. DATE SIGNED<br><b>8-1-68</b>  |  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Vicente M. Pivano</b>   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b> |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  |  | 23b. DATE<br><b>Aug. 4, 1968</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Emory</b>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Street, Harford, Maryland</b>            |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John H. Harkins, Delta, Penna.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 5 1968</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John H. Harkins</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |                   |   |  |                                   |  |
|--|--|------------------------------|--|---|-------------------|---|--|-----------------------------------|--|
| 11213  |  |                              |  |   |                   |   |  |                                   |  |
| 11227  |  |                              |  |   |                   |   |  |                                   |  |
| CERTIFICATE OF DEATH   |  |                              |  |   |                   |   |  |                                   |  |
| 1. DECEASED-NAME:<br>(Type or print)   |  |                              | First Middle Last  |   |                   | 2a. DATE OF DEATH   |  |                                   | 2b. HOUR                                     |
| Victor   |  |                              | St. Martin   |   |                   | Month Day Year<br>8 20 1968   |  |                                   | 10:05 AM                                     |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                   | 6. AGE (In years last birthday)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS    |  |
| Male   |  | White                        |  | July 26, 1891   |                   | 77 YRS.   |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |                                   |  |
| Canada   |  | U.S.A.                       |  |   |                   | Baltimore, Md.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Towson   |  |                              | ST. JOSEPH HOSPITAL  |   |                   | Pipe Fitter   |  | Steel                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| Maryland   |  |                              | Baltimore  |   | Baltimore         |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 35 Eastship Rd.                              |
| 14. FATHER'S NAME First Middle Last  |  |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |                   |   |  |                                   |  |
| Pierre St. Martin  |  |                              | Henretta Gaither   |   |                   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT     |   | Address  |                                   |  |
| yes  |  |                              | WWI  |   | 213-07-9943       |   | Mrs. Blanche K. St. Martin same as #13   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive pulmonary thrombo-embolism</u><br>575X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                              |  |   |                   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |   |                   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                              |  |   |                   |   |  |                                   |  |
| 8/9/68   |  |                              |  |   |                   |   |  |                                   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                              |  |   |                   |   |  |                                   |  |
| Cholecystitis  |  |                              |  |   |                   |   |  |                                   |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                              |  |   |                   |   |  |                                   |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |                              |  |   |                   |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              |  |   |                   |   |  |                                   |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |                              |  |   |                   |   |  |                                   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                              |  |   |                   |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  |   |                   |   |  |                                   |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |                              |  |   |                   |   |  |                                   |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                              |  |   |                   |   |  |                                   |  |
| 22a. I certify that (this hospital) attended the deceased from 8/6/68, 19, to 8/20/1968, that (we) (I) saw the deceased alive on 8/20/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                              |  |   |                   |   |  |                                   |  |
| 22b. SIGNATURE   |  |                              |  |   |                   |   |  |                                   |  |
| Reynaldo Orjuela-Gomez, M.D. OEGREE  |  |                              |  |   |                   |   |  |                                   |  |
| 22c. DATE SIGNED 8/20/68   |  |                              |  |   |                   |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.  |  |                              |  |   |                   |   |  |                                   |  |
| 22e. ADDRESS 7620 York Rd., Towson, Md. 21204  |  |                              |  |   |                   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              |  |   |                   |   |  |                                   |  |
| Burial   |  |                              |  |   |                   |   |  |                                   |  |
| 23b. DATE 8/23/68  |  |                              |  |   |                   |   |  |                                   |  |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National  |  |                              |  |   |                   |   |  |                                   |  |
| 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland  |  |                              |  |   |                   |   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |   |                   |   |  |                                   |  |
| Walter Brooks Bradley, Inc., Dundalk   |  |                              |  |   |                   |   |  |                                   |  |
| 25a. REC'D BY REGISTRAR  |  |                              |  |   |                   |   |  |                                   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |                              |  |   |                   |   |  |                                   |  |
| OATE AUG 21 1968   |  |                              |  |   |                   |   |  |                                   |  |

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2650 York Rd., Towson, Md. 21204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |   |  |  |  |
|--|--|--|--|---|--|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>JOHN HARDESTER SANDBERG</b>   |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>18</b> Year <b>68</b>   |   | 2b. HOUR<br><b>12:35</b>  |  |  |  |
| 3. SEX<br><b>M.</b>  |  | 4. RACE<br><b>Cau. (White)</b>   |  | 5. DATE OF BIRTH<br><b>6-28-1896</b>  |  | 6. AGE (In years lost birthday)<br><b>72</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO., MED. CEN.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov't.</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1307 Providence Rd.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Oscar B. Sandberg</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Hardester</b>  |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)<br><b>WW I</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-1257</b>   |   | 17. INFORMANT<br><b>Wife</b>   |   | Address<br><b>Same Address</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br><b>2079</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>LEUKEMIA</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>2044</b>   |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>8/17/68 68 8/18/68 68</b>  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/68</b> , 19 <b>68</b> , to <b>8/18/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/18/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/18/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>M.G. LAZARUS MBBS</b>  |  |  |  |   | 22e. ADDRESS<br><b>Greater Balto., Med.Center</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-22-1968 v</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DruidRidge Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>                                       |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>2 Wm. Cook-Brooks Towson Towson, Md. 21204</b>  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 20 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

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TO THE HONORABLE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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AM

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>John Joseph Sanders</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>8-23-68</b>                |   |  | 2b. HOUR<br><b>7:45</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>W Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>6-4-16</b>   |  | 6. AGE (In years lost birthday)<br><b>52</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Perth Amboy, N.J.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore Co Gen Hosp</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>ARMA Chemical</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Randallstown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8802 Meadow Heights Rd</b>        |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Frank Sanders</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Ann Stephens</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br><b>145-05-1857</b>   |  | 17. INFORMANT<br><b>Dr. Kain Montuarez</b> Address <b>431-33 State St. PERTH AMBOY, N.J.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic coronary art. disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> , 19 <b>62</b> , to <b>Aug.</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>June</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Philip Bernstein</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><b>8/23/68</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>8/26/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Gertrude's</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>COLONIA, N.J.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Norm Buero - 8728 Liberty Road Randallstown, Md.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 26 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |



2321

152



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |                                  |   |  |
|---|--|--|--|---|--|---|--|--|----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |                                  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                                  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Viola B. Scaggs</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>23</b> Year <b>1968</b>   |  |  | 2b. HOUR<br><b>7:00</b><br>a. m. |   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>Sept. 2, 1890</b>  |  | 6. AGE (In years last birthday)<br><b>77</b><br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |                                  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |                                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b>   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>seamstress</b> |                                  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Savage</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |                                  | 13e. STREET AND NUMBER<br><b>221 Washington St.</b> |  |
| 14. FATHER'S NAME<br>First <b>William C.</b> Middle <b>Krause</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Ella</b> Middle <b>Chalk</b>   |  |   |  |  |                                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>578-05-0764A</b>   |  | 17. INFORMANT<br>Address <b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  |                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |  |                                  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |                                  |   |  |
| IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  |  |  |   |  |   |  |  |                                  |   |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |                                  |   |  |
| Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause last. (b) <b>Myocardial infarction</b>  |  |  |  |   |  |   |  |  |                                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular heart disease</b>   |  |  |  |   |  |   |  |  |                                  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |                                  |   |  |
| 4201 <b>Diabetes mellitus</b>   |  |  |  |   |  |   |  |  |                                  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                                  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |                                  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1963</b> , to <b>Aug. 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |                                  |   |  |
| 22b. SIGNATURE<br><i>Evelio M. Felipe</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-23-68</b>   |                                  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Evelio M. Felipe</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |  |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>8-26-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Long Hill Cem</b>  |  | 23d. LOCATION (City or Town)<br><b>Lanham Md</b>  |  | County   |                                  | State   |  |
| 24. FUNERAL DIRECTOR<br><i>Donald J. Pomeroy</i>  |  |  |  |   |  | ADDRESS<br><i>Spring Grove State Hospital</i>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 30 1968</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><i>James Judge</i>    |  |

MEDICAL CERTIFICATION

STATE OF TEXAS

County of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

and the same is a true and correct \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11223  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                         |  |   |  | 11231   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |   |  | First Middle Last   |  | 20. DATE OF DEATH   |  |
| LOUISA   |  |   |  | C. SCHAROUN   |  | Month Day Year<br>August 15 1968  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>8-18-1882   |  | 6. AGE (In years lost birthday)<br>85 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>England   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |
| 13e. STREET AND NUMBER<br>3404 Ramona Ave., - 21206  |  | 14. FATHER'S NAME<br>First Middle Last<br>Charles   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Caroline   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br>Yes, no, or unknown |  |
| 16a. SOCIAL SECURITY NO.<br>218-12-3245  |  | 17. INFORMANT<br>218-12-3245  |  | 17. INFORMANT<br>Nr. F. Scharoun  |  | Address<br>3404 Ramona Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>2509<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arteriosclerotic cardio vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>260x |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/13/</u> , 19 <u>68</u> , to <u>8/15/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/15/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Lilia C. Baldonado</u>  |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>8-15-68</u>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Lilia C. Baldonado MD.   |  |   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8-19-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>B. Dabrowski 2818 E. Baltimore St.   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 23 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

11831

11832

OFFICE OF THE ATTORNEY GENERAL



RECEIVED 11-19-68

U.S. DEPARTMENT OF JUSTICE

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PMS-Page 5" may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11222

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11232

|   |  |                  |  |  |  |   |  |  |   |   |  |   |  |                        |  |
|---|--|------------------|--|--|--|---|--|--|---|---|--|---|--|------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>EMMA</b> First <b>M</b> Middle <b>SCHAEFFER</b> Last   |  |                  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>14</b> Year <b>1968</b>   |  |  | 2b. HOUR <b>M</b>   |  |  |   |   |  |   |  |                        |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH <b>4-2-89</b>   |  | 6. AGE (In years last birthday) <b>79</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>1</b>  |   | 8. IF UNDER 24 HRS.<br>HOURS <b>1</b> MIN. <b>0</b> |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Aug</b> Day <b>14</b> Year <b>1968</b> |  | 2d. HOUR <b>4:25</b> M |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>  |  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>BALTIMORE</b>   |   |  | Md.   |  |                        |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                                     |   |  |   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  |                  | 13b. COUNTY <b>BALTO</b>   |  |  | 13c. CITY OR TOWN <b>TIMONIUM</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER <b>163 SPRINGSIDE DR.</b>                            |  |                        |  |
| 14. FATHER'S NAME First <b>HERMAN</b> Middle <b>ENGEL</b> Last <b>CATHERINE</b>   |  |                  | 15. MOTHER'S MAIDEN NAME First <b>KREMER</b> Middle <b>KREMER</b> Last <b>KREMER</b>                 |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>215-50-3277</b>                                       |   |  | 17. INFORMANT ADDRESS <b>SAME AS # 13</b>                                   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b><br><b>887X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>FRACTURE, LEFT FEMORAL NECK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>99 DAYS</b>                                   |  |                  |  |  |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 HRS</b>               |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>9040</b>  |  |                  |  |  |  |   |  |  |   |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION <b>8/8/68</b>  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>H.P. FRACTURE</b>                   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |   |  |                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>   |  |                  |  | 21b. TIME OF INJURY Month, Day, Year <b>10 P.M. 8/5/68</b>                               |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>FELL</b>                                  |   |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b> |  |   |  | 21f. LOCATION Street or R.F.D. No. <b>163 SPRINGSIDE DR</b> City or Town <b>TIMONIUM</b> County <b>BALTO</b> State <b>MD</b> |   |   |  |   |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |   |  |  |   |   |  |   |  |                        |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>  |  |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | 22b. DATE SIGNED <b>8-14-68</b>  |   |   |  |   |  |                        |  |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |  |                  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                      |  |   |  | DEPUTY MEDICAL EXAMINER <b>Timonium</b>  |   |   |  |   |  |                        |  |
| ADDRESS (Street, city, town, or county) <b>W. Cook-Brooks Towson</b>  |  |                  |  | ADDRESS (Street, city, town, or county) <b>1050 YORK Rd. Towson, Md 21204</b>            |  |   |  | 25a. REC'D BY REGISTRAR <b>AUG 19 1968</b> REGISTRAR'S SIGNATURE <b>John Judge</b>   |   |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                  |  | 23b. DATE <b>Aug. 17 1968</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>   |   |   |  |   |  |                        |  |
| 23d. LOCATION (City or Town) <b>Parkville</b> (County) <b>BALTO</b> (State) <b>MD</b>   |  |                  |  | 23e. LOCATION (City or Town) <b>Towson</b> (County) <b>BALTO</b> (State) <b>MD</b>       |  |   |  | 23f. LOCATION (City or Town) <b>Towson</b> (County) <b>BALTO</b> (State) <b>MD</b>   |   |   |  |   |  |                        |  |

11332

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

FOR THE

(1)

THE NO. 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

|   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 11225   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 11233  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Bessie May Schmidt  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>Aug. 1, 1968  |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>9:45 A   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female  |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>Sept. 25, 1885  |  |  |  |  | 6. AGE (In years lost birthday)<br>82 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>301 Gwynnbrook Ave. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  | 13c. CITY OR TOWN<br>Owings Mills   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>301 Gwynnbrook Ave.              |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Charles David Moser  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Martha Isabell Eby                                    |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)<br>No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>216-03-8442   |  |  |  |  | 17. INFORMANT Address<br>D Mrs. Ross Pierpont 5602 Enderly Rd. Balto., Md. 21212  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Chronic</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Weeks</u><br><u>Year</u> |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4500  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 1, 1963</u> , to <u>August 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Clarence E. McWilliams</u>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED<br>8-2-68  |  |  |  |  |  |  |  |  |  | 22d. FUNERAL DIRECTOR NAME (Type)<br>Clarence E. McWilliams |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS<br>11904 Reis. Rd., Reisterstown Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  | 23b. DATE<br>Aug. 5, 1968   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co., Md.                             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>H. J. Schardt</u> Owings Mills, Md.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 5 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>          |  |  |  |  |  |  |  |  |  |

11382

11382

RECEIVED  
JAN 11 1962  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 11226   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  |   |  | 11234  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Harry C. Schnepfe</b>   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>Aug. 1, 1968</b> |   |  | 2b. HOUR<br><b>8:55 P M</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Sept. 16, 1883</b>   |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Shangri La. Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Vice President</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>John W. Schnepfe</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine E.</b>                                       |  | 13e. STREET AND NUMBER<br><b>S. Symington Ave.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-14-5502</b>  |  | 17. INFORMANT Address <b>Balto. Md.</b><br><b>Mr. Arthur G. Schnepfe 3422 Frederick Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Hypertensive Pneumonia</b><br><b>4120</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>16 years</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>143x 10 weeks Mellitus</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/7</b> , 19 <b>58</b> , to <b>8/1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. W. Johnson</b>  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>8/2/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>E. W. Johnson</b>  |  |   |  | 22e. ADDRESS<br><b>3432 Frederick Ave. Balto. Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>Aug. 5, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Mausoleum</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Balto. Md.</b>                 |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab 5151 Balto. National Pike</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 7 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

11008

11008

Aug. 1, 1963

Connors

Army

Male

White

Sept. 16, 1963

Barro

U. S. A.

Barro

Sharon J. Hono

Vino Street and

Castanville

Castanville

Barro

Barro

Barro

John E. Connors

217-11-102

Mr. Arthur E. Connors

E. J. Thompson

Aug. 3, 1963

Connors and Connors

Woodland

U. S. Army Corps of Engineers

Aug 7 1963

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VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |   |                                    |  |
|--|--|--|--|--|---|---|---|------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |                                    |  |
| 11227 CERTIFICATE OF DEATH 11235   |  |  |  |  |   |   |   |                                    |  |
| 1. DECEASED NAME<br>(Type or print) <b>Cecelia</b>   |  |  | First <b>S.</b> Middle <b>S.</b> Last <b>Schueler</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>10</b> Year <b>1968</b>                                     |   |                                    | 2b. HOUR<br><b>5:15am</b>  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>May 12, 1885</b>                        |   |   | 6. AGE (In years last birthday)<br><b>83</b> YRS.   |                                    | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    | 13e. STREET AND NUMBER<br><b>2907 Bayonne Ave.</b>               |
| 14. FATHER'S NAME<br><b>Joseph F. Whelple</b>  |  |  | First <b>S.</b> Middle <b>S.</b> Last <b>Schueler</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Elizabeth M. Hoernig</b>   |   |                                    | First <b>S.</b> Middle <b>S.</b> Last <b>Schueler</b>            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-9662</b>   |  | 17. INFORMANT<br><b>Mrs Beulah E. Francis</b>   |   |   | Address<br><b>2907 Bayonne Ave</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive intraabdominal hemorrhage</b><br><b>452x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Portal thrombosis</b><br><b>452</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>466x</b> |  |  |  |  |   |   |   |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>8-6</b> , 19 <b>68</b> , to <b>8-10</b> , 19 <b>68</b> , that (X) (we) lost the deceased alive on <b>8-10-68</b> 19 <b>68</b> , and that in (not) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |   |                                    |  |
| 22b. SIGNATURE<br><b>W. C. Cilliani</b>  |  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>            |   | 22c. DATE SIGNED<br><b>8-10-68</b>  |                                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  |  |  |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Maryland 21204</b>   |   |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/13/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc Baltimore, Md.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 12 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                    |  |



1133

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF CRIME

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| <div style="display: flex; justify-content: space-between;"> <div> 11228<br/> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> Item 23b, telephone call Stansbury F. H. 8/7/68 cac </div> <div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>CERTIFICATE OF DEATH</div> </div> </div> <div> 11236 </div> </div>                                |  |  |   |  |   |   |  |  |   |                             |  |
|---|--|--|---|--|---|---|--|--|---|-----------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>WILLIAM SEIDLICH, SN</b>   |  |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br><b>8 3 1968</b>   |  |  | 2b. HOUR<br><b>4:45A M</b>  |                             |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>8/9/1892</b>  |   | 6. AGE (In years last birthday)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                            |   | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>WOODLAWN</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6713 WINDSOR MILL RD</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FLORIST</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>WOODLAWN</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6713 WINDSOR MILL RD</b>   |                             |  |
| 14. FATHER'S NAME First Middle Last<br><b>FREDERICK AUGUST SEIDLICH</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>CAROLINE KELLER</b>   |   |   |  |  |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or of unknown (If yes give war or dates of service)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-3138</b>  |  | 17. INFORMANT<br><b>WIFE - RUTH SEIDLICH</b>                                      |   |  | Address <b>6713 WINDSOR MILL RD</b>                    |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEMORRHAGE - GESOPHAGEAL VARIX</b><br><b>436.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CEREBRAL APOPLEXY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSION</b> |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 HOURS</b><br><b>5 MONTHS</b><br><b>20 YEARS</b> |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>334 X</b>   |  |  |   |  |   |   |  |  |   |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |   |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County   |   | State                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 10, 1950</b> to <b>AUG. 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>AUG. 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |   |  |  |   |                             |  |
| 22b. SIGNATURE<br><b>Edwin L. Pierpont, M.D.</b> DEGREE   |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |   | 22c. DATE SIGNED<br><b>AUGUST 3, 1968</b>   |  |  |   |                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EDWIN L. PIERPONT, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>8204 LIBERTY RD - BALTO 21207 MD</b>  |   |   |  |  |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 8, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Balto Co Md</b>                              |  |  |   |                             |  |
| 24. FUNERAL DIRECTOR<br><b>John T. Stansbury 6411 Windsor Mill Rd.</b>  |  |  |   | ADDRESS<br><b>21207</b>  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 7 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John T. Stansbury</b> |   |                             |  |

2851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |                                   |   |  |
|---|--|--|--|---|--|---|--|---|-----------------------------------|---|--|
| <div>11229</div> <div>CERTIFICATE OF DEATH</div> <div>11237</div>   |  |  |  |   |  |   |  |   |                                   |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>August A Seifert  |  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>8 25 68   |  |   | 2b. HOUR<br>4:30 P.M.             |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>June 3, 1884  |  | 6. AGE (In years lost-birthday)<br>84 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.                          |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Germany  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Chesapeake Manor |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Engraver |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |  |  | 13b. COUNTY<br>Balto.  |   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER<br>455 Range Rd                  |  |
| 14. FATHER'S NAME First Middle Last<br>Andreas Seifert  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Christine Zimmerman   |  |   |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  | 17. INFORMANT<br>Lillian M Seifert  |  |   | Address<br>Same                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Uremia<br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4500   |  |  |  |   |  |   |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |                                   | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 5, 1968, to Aug 25, 1968, that (I) (we) last saw the deceased alive on Aug 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                     |  |  |  |   |  |   |  |   |                                   |   |  |
| 22b. SIGNATURE<br>George T. Gilmore M.D.  |  |  |  |   |  | 22c. DATE SIGNED<br>Aug 26, 1968  |  |   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>George T Gilmore M.D.   |  |  |  |   |  | 22e. ADDRESS<br>Lanham Bldg. Lutherville Md   |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>8/28/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md                                      |  |   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>Leonard J Ruck Inc Baltimore Md.  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>AUG 26 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>for [signature]   |                                   |   |  |



11230

CERTIFICATE OF DEATH

11238

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM</b>   |  |  | First Middle Last<br><b>EDWARD SELLARS</b>   |  |  | 2a. DATE OF DEATH<br><b>Aug</b> Month <b>23</b> Day <b>1968</b>   |  |  | 2b. HOUR<br><b>M</b>   |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>May 27, 1914</b>   |  |  | 6. AGE (In years last birthday)<br><b>54</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4210 Leeds Ave.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Interior Decorator</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Interior Decorator</b>                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>4210 Leeds Ave., 21229</b>  |  |  | 14. FATHER'S NAME First Middle Last<br><b>Thomas Sellars</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Eunice Abernathy</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-8274</b>   |  |  | 17. INFORMANT Address<br><b>Mrs. Edith B. Sellars, 4210 Leeds Ave., Balto.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA - LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo - 1 yr</b> |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1638</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-10</b> , <b>1968</b> , to <b>8-23</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> , <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Norman R. Kleiman</b> DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  | 22c. DATE SIGNED<br><b>8/23/68</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>NORMAN R. KLEIMAN</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>3803 EDMONDSON AVE -</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Aug. 26, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Church Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Lively Virginia</b>                      |  |  |
| 24. FUNERAL DIRECTOR<br><b>Flynn &amp; Fleming</b> ADDRESS<br><b>1422 Light St. Balto. Md.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 26 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

11239

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                      |   |   |  |
|--|----------------------|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>MARYANN (MARYANN) SHAYDA</b>  |                      | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>August 1, 1968</b> |   | 2b. HOUR <b>7:00 P.M.</b>  |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>Nov. 14, 1956</b>   | 6. AGE (In years last birthday) <b>10 1/2</b> RS. | 7c. DATE PRONOUNCED DEAD <b>Month August 1, 1968</b>   |
| 7a. BIRTHPLACE (State or foreign country) <b>U.S.S.R. Md.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH <b>Baltimore</b>  |                      | 10. CITY OR TOWN OF DEATH <b>Parkville</b>  |   |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3031 Woodside- Basement</b>  |                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>                                  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>  |                      | 13b. CITY OR TOWN <b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME First <b>Joseph</b> Middle <b>Rudolph</b> Last <b>Shayda</b>   |                      | 15. MOTHER'S MAIDEN NAME First <b>Alberta</b> Middle <b>Natisky</b> Last <b>Balto.,</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>None</b>  |   | 17. INFORMANT ADDRESS <b>Joseph R. Shayda: 413 S. Macon St. 21224, Md.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Stab Wounds of Chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>966x</b>  |                      |   |   |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                      | 21b. TIME OF INJURY Month, Day, Year <b>6:00 P.M. August 1, 1968</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Stab wounds of Chest</b>  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Basement</b>  |   | 21f. LOCATION Street or R.F.D. No. <b>3031 Woodside</b> City or Town <b>Baltimore</b> County <b>M.D.</b>   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |   |   |  |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>   |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>August 2, 1968</b>   |
| EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |                      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |
|  |                      | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |  |
| ADDRESS (Street, city, town, or county)  |                      |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 23b. DATE <b>8-6-68.</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Com.</b>  |
| 23d. LOCATION (City or Town) (County) <b>Baltimore, Md.</b>  |                      | 23d. LOCATION (City or Town) (County) <b>7401 Gorman Hill Rd. Baltimore, Md.</b>  |   |  |
| 24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>  |                      | 25a. REC'D BY REGISTRAR <b>DATE AUG 8 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                              |   |                            |  |   | 11240   |   |                                   |  |
|--|--|--|--|--|------------------------------|---|----------------------------|--|---|---|---|-----------------------------------|--|
| 11232  |  |  |  |  |                              |   |                            |  |   | CERTIFICATE OF DEATH  |   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>JOHN</b>   |  | Middle<br><b>SHELLHAMMER</b> |   | Last<br><b>SHELLHAMMER</b> |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>1</b> Year <b>68</b>                                 |   | 2b. HOUR<br><b>7:00P</b> M                              |                                   |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |                              | 5. DATE OF BIRTH<br><b>7/29/00</b>  |                            |  | 6. AGE (In years<br>last birthday)<br><b>68</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.               |                                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>UPPER LEIGH, PA.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.   |   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital<br>give street address)<br><b>VET. ADM. HOSPITAL</b> |  |                              | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>JANITOR</b>  |                            |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>FACTORY</b>  |   |   |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |                              | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1211 S. Clinton Street</b> |                                   |  |
| 14. FATHER'S NAME<br>First <b>FRANK</b><br>Middle<br>Last <b>SHELLHAMMER</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>DORA</b><br>Middle<br>Last <b>KRESGE</b>                                |  |                              |   |                            |  |   |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW 11</b>   |  |                              | 16c. SOCIAL SECURITY NO.<br><b>198 05 26 63</b>   |                            |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>                   |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEMOPTYSIS, MASSIVE</b><br><b>492X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PULMONARY EMPHYSEMA MARKED</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |                              |   |                            |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>5271 ARTERIOSCLEROTIC HEART DISEASE</b>  |  |  |  |  |                              |   |                            |  |   |   |   |                                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                              | 20a. AUTOPSY?<br><b>YES</b> NO <input type="checkbox"/>   |                            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>YES</b>              |   |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                            |  |   |   |   |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |  |                              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                            |  |   |   |   |                                   |  |
| 22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>7/25/68</b> , 19____, to <b>8/1/68</b> , 19____, that <b>(X)</b> (we) last saw the deceased alive on <b>8/1/68</b> , 19____, and that in <b>(X)</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (we) (did) (did not) view the body after death.             |  |  |  |  |                              |   |                            |  |   |   |   |                                   |  |
| 22b. SIGNATURE<br><b>Peter V. Juvan</b>  |  |  |  |  |                              |   |                            |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/2/68</b> |  |
| 22d. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>  |  |  |  |  |                              |   |                            |  |   | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |                                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>8-5-68</b>   |  |                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |                            |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |   |   |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Theresa A. Hoffman</b>  |  |  |  |  |                              | ADDRESS<br><b>HOFFMAN FUNERAL HOME</b>  |                            |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>      |                                   |  |
| <b>3218 Hudson Street, Baltimore, Md.</b>  |  |  |  |  |                              |   |                            |  |   |   |   |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be telephoned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11233  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                     |  |   |  | 11241   |  |
|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or print)<br><b>SHERMAN</b>  |  | Middle  |  | 2a. DATE OF DEATH<br>Month <b>Aug</b> Day <b>23</b> Year <b>1968</b>  |  | 2b. HOUR<br><b>5:20</b> PM  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>9.22.90</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randalls town</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore County General</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>MERCHANT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>3 Arrowhead Court #8</b>  |  | 14. FATHER'S NAME First <b>PHILIP</b> Middle <b>SHERMAN</b> Last <b>SHERMAN</b>                                 |  | 15. MOTHER'S MAIDEN NAME First <b>DEVORAH</b> Middle <b>?</b> Last <b>?</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. 11 ARMY</b>   |  | 17. INFORMANT<br><b>XXXXXX</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1638</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>chronic obstructive lung disease</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jul 20, 1968</b> to <b>Aug 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Gregorio Wearfon</b>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                 |  | 22c. DATE SIGNED<br><b>Aug 23, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GREGORIO WEARFON</b>  |  |   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8-25-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH AITZ CHAIM</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 27 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |                                   |  |  |
|--|--|--|--|--|--|---|--|--|-----------------------------------|--|--|
| 11234  |  | CERTIFICATE OF DEATH   |  |  |  |   |  | 11242  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |  |  |
| Ira J. Shiflett  |  |  |  |  |  | Aug. 8, 1968  |  |  | M                                 |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                   |  |  |
| Male   |  | White  |  | Dec. 10, 1892  |  |   | 75 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |  |                                   |  |  |
| Va.  |  | U. S. A.   |  |  |  |   | Baltimore Md.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Catonsville  |  |  | Summit Home  |  |  | Farmer  |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |  |
| Md.  |  |  | Howard   |  |  |   |  |  | Meadowridge Rd. Rt. 4 Box 305 R   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |                                   |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  |   |  |  |                                   |  |  |
| Rufus Shiflett   |  |  | Selana Morris  |  |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |  |  |                                   |  |  |
| No   |  |  |  |  | Meadowridge Rd. Address 21227 Mrs. William Zimmitsky Rt. 4 Box 305 R |   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |                                   |  |  |
| IMMEDIATE CAUSE (a) <i>Acute respiratory failure</i>   |  |  |  |  |  |   |  |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Thrombosis</i>   |  |  |  |  |  |   |  |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Advanced arteriosclerosis</i>  |  |  |  |  |  |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |                                   |  |  |
| 332 X  |  |  |  |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |  |
|  |  |  |  |  |  |   |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                                   |  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                   |  |  |
|  |  |  |  |  |  |   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 10, 1968</i> to <i>8 Aug. 1968</i> , that (I) (we) last saw the deceased alive on <i>8 Aug. 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE <i>William J. Bryson</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <i>8 Aug 68</i>  |  |  |  |  |  |   |  |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>William J. Bryson</i> 22e. ADDRESS <i>4605 Edmondson</i>   |  |  |  |  |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |  |
| Burial   |  | Aug. 10, 1968  |  | Meadowridge Cemetery   |  |   | Baltimore, Maryland  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| G. Truman Schwab, 3512 Frederick Ave., Baltimore, Md. 21229  |  |  |  |  |  | AUG 12 1968   |  | <i>Charles Judge</i>   |                                   |  |  |

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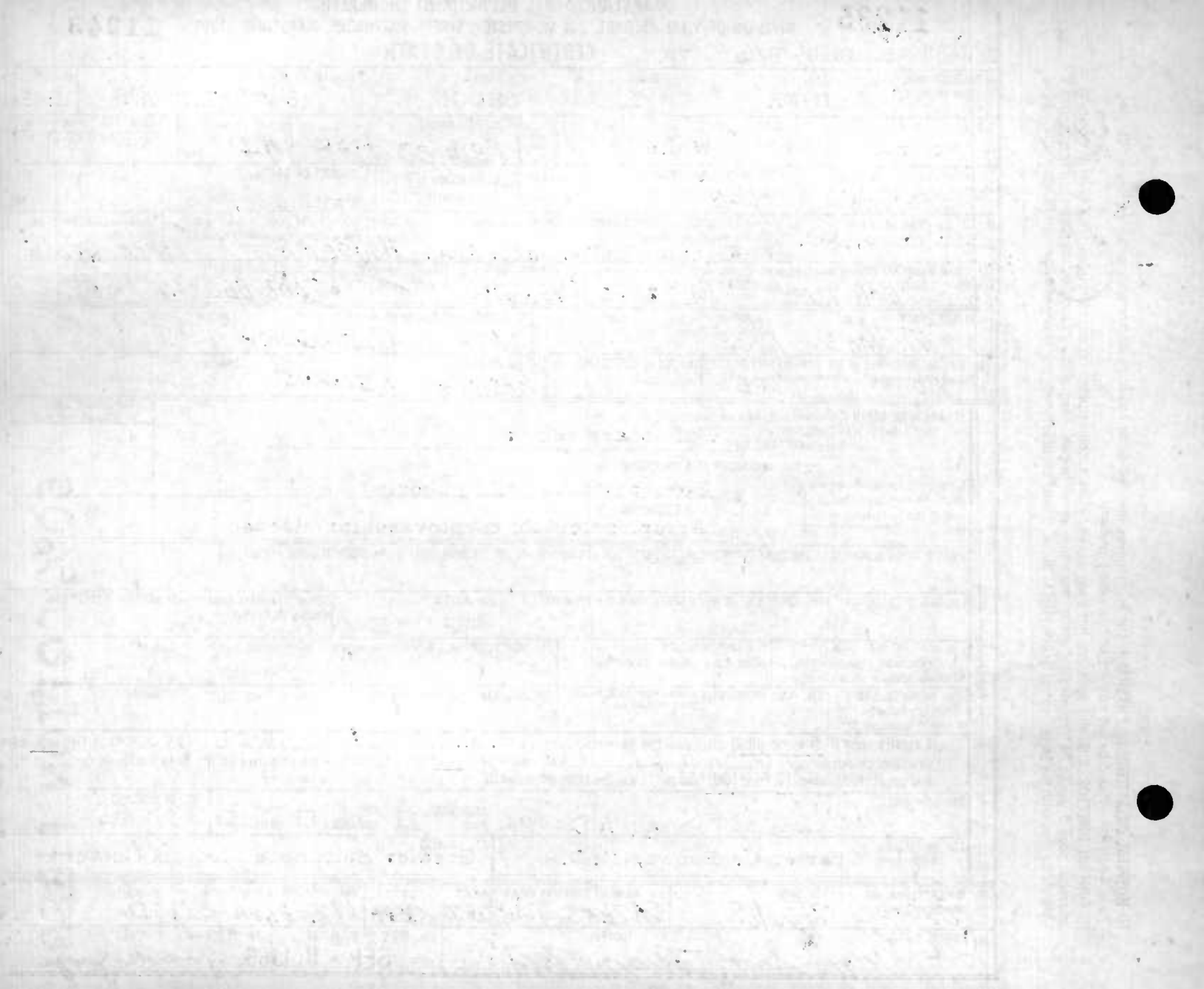
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |                                     |   |  |   |   |
|--|-------------------------------------|---|--|---|---|
| 11235  |                                     | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  | 11243   |   |
| Item#8 Film#G404 9/6/68 vmp  |                                     | CERTIFICATE OF DEATH  |  |   |   |
| 1. DECEASED-NAME: First Middle Last<br>(Type or print) ESTHER I SHOCK  |                                     |   | 2a. DATE OF DEATH<br>8 Month 28 Day 68 Year  |   | 2b. HOUR P<br>11:45 M   |
| 3. SEX<br>Female   | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>FEB. 23, 1894   |  | 6. AGE (In years last birthday)<br>74 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore, Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Cen.  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND   |                                     | 13b. COUNTY BALTIMORE   | 13c. CITY OR TOWN RIDERWOOD  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br>8008 BELLONA AVE.                     |
| 14. FATHER'S NAME First Middle Last<br>THOMAS INCE   |                                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br>KATY YEAGLE-QUIRK   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO  |                                     | 16b. SOCIAL SECURITY NO.<br>NONE  |  | 17. INFORMANT<br>FAMILY RECORDS   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary edema<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Coronary artery thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic cardiovascular disease |                                     |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201  |                                     |   |  |   |   |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 p.m. 8/28/68, to 8/28/1968, that (I) (we) last saw the deceased alive on 8/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                                     |   |  |   |   |
| 22b. SIGNATURE<br>Charles C. Brown, M.D.   |                                     | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>8/29/68   |   |
| 22d. PHYSICIAN'S NAME (Type)<br>Charles C. Brown, M.D.   |                                     | 22e. ADDRESS<br>Greater Baltimore Medical Center  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                     | 23b. DATE<br>8/30/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SATER'S BAPTIST CEM.                                      |   |
| 23d. LOCATION (City or Town) (County) (State)<br>LUTHERVILLE, MD.  |                                     |   |  |   |   |
| 24. FUNERAL DIRECTOR<br>John Brown, Son, Funeral Home  |                                     | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 3 1968  |   |
|  |                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br>j. Charles Judge  |   |



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11236

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11244

|  |  |  |       |   |  |   |  |                                |               |  |      |
|--|--|--|-------|---|--|---|--|--------------------------------|---------------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                | 2b. HOUR<br>M |  |      |
| ELSIE MAY SHORT  |  |  |       |   |  | August 4, 1968  |  |                                | 50            |  |      |
| 3. SEX   |  | 4. RACE  |       | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |               | IF UNDER 24 HRS.<br>HOURS MIN                |      |
| Female   |  | White  |       | May 11, 1892  |  | 76 YRS.   |  |                                |               |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                |               |  |      |
| Maryland   |  | U.S.A.   |       |   |  | Baltimore Md.   |  |                                |               |  |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |               |  |      |
| Owings Mills   |  | Baptist Home of Md.  |       | Housewife   |  | Home  |  |                                |               |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |               |  |      |
| Maryland   |  |  |       | Baltimore   |  |   |  | 3706 Mohawk Ave.               |               |  |      |
| 14. FATHER'S NAME  |  |  | First | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |                                | First         | Middle                                       | Last |
| Thomas W. Edes   |  |  |       |   |  | Sarah E. Packer   |  |                                |               |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT Address   |  |   |  |                                |               |  |      |
| No   |  | 216-03-6780  |       | Baptist Home of Md. Owings Mills, Md.   |  |   |  |                                |               |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Intestinal Tract.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old age</u> |  |  |       |   |  |   |  |                                |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>1539</u>   |  |  |       |   |  |   |  |                                |               |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |               |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                |               |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                |               |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Aug 4, 1968 that (I) (we) last saw the deceased alive on Aug 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |       |   |  |   |  |                                |               |  |      |
| 22b. SIGNATURE<br><u>Dr. Paul M. Beyerly</u>   |  |  |       |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8/5/68   |                                |               |  |      |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Paul M. Beyerly  |  |  |       |   | 22e. ADDRESS<br>5820 York Rd. Baltimore, Md.   |   |  |                                |               |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>7-7-68  |       | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn, Md.                                  |  |                                |               |  |      |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home, Inc. 6500 York Rd.  |  |  |       |   | 25a. REC'D BY REGISTRAR<br>DATE AUG 7 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |                                |               |  |      |





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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>PHILIP SIGISMONDI</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>3</b> Year <b>68</b>               |   |  | 2b. HOUR <b>6:15</b> P.M.   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br><b>3/10/97</b>  |  | 6. AGE (In years lost birthday)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREAT. BALT. MED. CEN.</b>           |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Cement Finisher</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>402 N. Collington Ave</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Nicholas - Sigismondi</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Dominica Beradenali</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 01 6453</b>  |   | 17. INFORMANT Address<br><b>Lucy E. Sigismondi 402 N. Collington Ave.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC AND RESPIRATORY ARREST</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>LUNG CARCINOMA WITH BRAIN METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>163x</b>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>-----</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-----</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-----</b>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>-----</b> Month <b>-----</b> Day <b>-----</b> Year <b>1968</b><br>P.M. <b>-----</b> |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>-----</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>-----</b>                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>-----</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/23</b> , 19 <b>68</b> , to <b>8/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/3</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Faramarz Naetm</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/3/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>FARAMARZ NAETM, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>6701 N. CHARLES ST BALT, MD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug 7, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Dippel Bro's Inc. 1800 E. Lombard St.</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>AUG 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11239

11246

CERTIFICATE OF DEATH

|  |  |   |        |   |  |   |  |   |                                |
|--|--|---|--------|---|--|---|--|---|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>LOUISE</b>  |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>13</b> Year <b>68</b>                     |   | 2b. HOUR<br><b>2:40</b> <b>am</b>                                    |   |                                |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |        | 5. DATE OF BIRTH<br><b>April 2, 1899</b>  |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS                         | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   |                                |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give nearest place)<br><b>GREATER BALTO., MED. CEN.</b> |        | 12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.)<br><b>Real Estate</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |        | 13c. CITY OR TOWN<br><b>Ruxton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1302 Locust Ave.</b> |                                |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Baruch</b> Last <b>Clagett</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Katherine</b> Middle <b>Duckett</b> Last <b>Duckett</b>                    |        |   |  |   |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWI</b>  |        | 17. INFORMANT<br><b>James M. Sill</b> Address <b>1302 Locust Ave. 21204</b>   |  |   |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4109</b> MYOCARDIAL INFARCTION<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |        |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>   |  |   |        |   |  |   |  |   |                                |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>8/12 68 8/13 68</b>  |  |   |  |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/13/68</b> to <b>8/13/68</b> , that (I) (we) last saw the deceased alive on <b>8/13/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |        |   |  |   |  |   |                                |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE  |        | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/13/68</b>  |  |   |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. RHODEN H.M.</b>   |  | 22e. ADDRESS  |        |   |  |   |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/15/68</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Trinity Church Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rt. 50 near Bowie, Md.</b>                  |  |   |                                |
| 24. BURIAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>   |  |   |        | 25a. REC'D BY REGISTRAR<br><b>AUG 15 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |                                |

STATE OF TEXAS

1901

10

THE STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please, remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11239  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 11247   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MARY   |  |  |  |  |  |  |  |  |  | E.  |  |  |  |  |  |  |  |  |  | SIMMS   |  |  |  |  |  |  |  |  |  | Month Day Year<br>August 13 68  |  |  |  |  |  |  |  |  |  | 6:30 PM  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  |  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>3-25-1881   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)<br>87 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence Before admission) STATE<br>Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Parkville  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>9127 Belair Rd., - 21236         |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>Benjamin Burton   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Mary Kirkendall   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>NA   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-44-5324   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Marian Miller 9127 Belair Road   |  |  |  |  |  |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>485X</u> <u>BRONCHOPNEUMONIA, Arterial sclerotic heart</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>disease and congestive failure.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>491X</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/17, 1968</u> , to <u>8/17, 1968</u> , that (I) (we) last saw the deceased alive on <u>8/17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Luis E. Renjel</u>  |  |  |  |  |  |  |  |  |  | DEGREE  |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>8-13-68   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Luis Renjel MD.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE<br>8/17/68  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Belair Road  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 16 1968   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

11521

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

11521



RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |  |  |  |  |
|--|--|--|--|---|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |  |  |  |
| 11240  |  |  |  |   |   |   |  |  |  |  |  |
| 11248  |  |  |  |   |   |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>CHARLES C. SMICK  |  |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>August 18, 1968                    |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>May 29, 1899  |   | 6. AGE (In years last birthday)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Arbutus   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>5602 Carville Avenue |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Arbutus  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>5602 Carville Avenue 21227             |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Henry Smick   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Vera Hicks  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>216-10-8578                                      |  | 17. INFORMANT Address<br>Mrs. Grace E. Smick, 5602 Carville Ave. 21227  |   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u><br>150X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>150X  |  |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State              |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>68</u> , to <u>8/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>James N. Frederick</u><br>Dr. James N. Frederick  |  |  |  |   | 22c. DATE SIGNED<br>8/19/68   |   | 22d. PHYSICIAN'S NAME (Type)<br>Dr. James N. Frederick               |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>8-22-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. <del>XXXXX</del> Maria Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Maryland                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE AUG 21 1968                               |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |  |  |  |  |

11008

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11249  |  |  |  |  |   |   |  |  |   | 11249   |  |  |  |  |                               |  |  |  |  |
|--|--|--|--|--|---|---|--|--|---|---|--|--|--|--|-------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Lost   |   |  |  |   | 2a. DATE OF DEATH<br>Month 8 Day 14 Year 68             |  |  |  |  | 2b. HOUR<br>6:30 P            |  |  |  |  |
| CATHERINE JANE SMITH   |  |  |  |  |   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>CAUCASIAN   |  |   | 5. DATE OF BIRTH<br>9-1-21  |  |  | 6. AGE (In years<br>lost birthday)<br>46 YRS.   |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |   |  |  |  |  |                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GREAT BALT. MED CENT. |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Clerk   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Telephone   |   |  |  |  |  |                               |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.   |  |  | 13b. COUNTY<br>BALTIMORE   |  |   | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br>5689 Purdue Ave. 21212 |  |  |                               |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Lost<br>James G. Smith   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br>Anna Krabbe  |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-14-2133   |   |  |  |   | 17. INFORMANT<br>Address<br>Anna E. Smith (Mother) Same |  |  |  |  |                               |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>2001</u> <u>CARDIAC AND RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>DEHYDRATION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>LYMPHO SARCOMA</u> |  |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |  |  |  |  |                               |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)<br><u>2001</u>  |  |  |  |  |   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |  |  |  |  |                               |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> , 19 <u>68</u> , to <u>8/14</u> , 19 <u>68</u> , that (I) (we) lost<br>saw the deceased alive on <u>8/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Naeim</u>   |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |  |  |   | 22c. DATE SIGNED<br>8/14/68                             |  |  |  |  |                               |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>FARAMARZ NAEIM, MD.D</u>  |  |  |  |  | 22e. ADDRESS<br><u>6701 N CHARLES ST BALT, MD</u>   |   |  |  |   |   |  |  |  |  |                               |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>8/19/1968   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Memorial   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Md.                              |   |  |  |  |  |                               |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Eugenia K. Seitz 5209 York Road<br>Seitz Funeral Home Baltimore, Md. 21212  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 19 1968  |   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>      |  |  |  |  |                               |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11242

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11250

# CERTIFICATE OF DEATH

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES</b> First <b>BURTON</b> Middle <b>SMITH</b> Last   |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>28</b> Year <b>68</b>   |  | 2b. HOUR<br><b>5:15</b> AM   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>AUGUST 9, 1976</b>   |  | 6. AGE (In years last birthday)<br><b>92</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>WOODLAWN</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6727 WINDSOR MILL RD.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FIREMAN</b>                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>WOODLAWN</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               | 13e. STREET AND NUMBER<br><b>6727 WINDSOR MILL RD.</b>                               |  |
| 14. FATHER'S NAME First <b>CHARLES</b> Middle <b>SMITH</b> Last   |  | 15. MOTHER'S MAIDEN NAME First <b>EMMA</b> Middle <b>CUTCHER</b> Last   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>218-26-0569</b>  | 17. INFORMANT <b>DAUGHTER Michel</b> Address <b>6727 WINDSOR MILL RD. BALTO, 21207 Md.</b><br><b>MRS. VIRGINIA MICHAEL</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>792X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE MONTH</b>       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>792X</b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 26, 1954</b> to <b>AUGUST 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edwin Pierpont, M.D.</b>   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>8/28/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EDWIN L. PIERPONT, M.D.</b>  |  | 22e. ADDRESS<br><b>8204 LIBERTY RD - BALTO, 21207 Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>8-31-68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park Cemetery - Baltimore, Md.</b>  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br><b>Ellsworth Armacast</b>   |  | ADDRESS<br><b>4601 Liberty Heights</b>  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 28 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11243

CERTIFICATE OF DEATH

11251

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>REGINALD L. SMITH JR</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Aug</b> Day <b>3</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>5:40 P</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>C</b>  |   | 5. DATE OF BIRTH<br><b>10-15-17</b>   |  | 6. AGE (In years lost birthday)<br><b>50</b> YRS.                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTO COUNTY GEN'L Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>U.S. Post Office</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTO</b>   |   | 13c. CITY OR TOWN <b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>2327 BRADDISH AVE</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>REGINALD L. SMITH JR.</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>LUCABER</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>XXXX</b>  |   | 17. INFORMANT<br><b>ELIZABETH SMITH 2327 BRADDISH AV</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>WIDESPREAD METASTATIC</b><br><b>157.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PANCREATIC CARCINOMA (HEAD)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157X</b> |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MO</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> 19 <b>68</b> , to <b>8/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/3</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Gregorio C. Wearfor</b>  |  |  |   | 22c. DATE SIGNED<br><b>8/3/68</b>   |  | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>8/8/1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO MD</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>Marlow P. Hays 638 N. Gilmor</b>   |  |  |   | 25a. BY REGISTRAR<br><b>AUG 5 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Antonio Judge</b>                                |  |

12-23

UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

12-23



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11244

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11252

|  |         |   |  |   |  |   |  |  |  |  |  |   |                   |   |  |
|--|---------|---|--|---|--|---|--|--|--|--|--|---|-------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First   |  | Middle  |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED <input checked="" type="checkbox"/> Month Day Year   |  |  |  | 2b. HOUR<br>M   |                   |   |  |
| CHARLES  |         | A.  |  | SNEEL   |  |   |  | 19   |  |  |  | M   |                   |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>Month Year |  |   | 2d. HOUR<br>P. M. |   |  |
| male   | negro   | June 30, 1925   |  | 43 YRS.   |  |   |  |  |  | August 12, 1968                        |  |   | 4:50 P. M.        |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |  |  |   | Md.               |   |  |
| Elkridge Md.   |         | U.S.A.  |  |   |  | Baltimore   |  |  |  |  |  |   |                   |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |  |   |                   |   |  |
| Baltimore (Sparrows Point)   |         | Bethlehem Steel Hospital  |  | Laborer   |  | Steel   |  | Bethlehem  |  |  |  |   |                   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |   |                   |   |  |
| Maryland   |         | -   |  | Baltimore   |  |   |  | 2311 Koko Lane   |  |  |  |   |                   |   |  |
| 14. FATHER'S NAME  |         | First   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First                                  |  | Middle  |                   | Last  |  |
| Edward   |         | Snell   |  |   |  |   |  | Sadie Emma   |  | Jackson                                |  |   |                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |   |                   |   |  |
| Yes  |         | 1943-1945   |  | 219-18-3201   |  | Mrs. Sadie Bell Fields  |  | Box #307   |  | Elkridge Md.                           |  |   |                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |   |  |   |  |   |  |  |  |  |  |   |                   |   |  |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |                   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |                   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |  |   |  |   |  |  |  |  |  |   |                   |   |  |
| ACTUAL<br>SIGNATURE  |         |   |  | Werner U. Spitz, M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  | 22b. DATE SIGNED<br>8/13/68                                   |                   |   |  |
| EXAMINER'S<br>NAME (Type)  |         |   |  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  |   |  | 23b. DATE<br>8/16/68   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem. |                   |   |  |
|  |         |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland  |  |   |  | 24. FUNERAL DIRECTOR<br>ADDRESS<br>Herbert E. Nutter-3035 W. North Ave.  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 14 1968                   |                   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |

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1104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
|---|--|--|--|---|-------------------|---|---|--|-----------------------------------|---|--|-------------------|--|
| 11245   |  | CERTIFICATE OF DEATH   |  |   |                   |   |   | 11253  |                                   |   |  |                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |   | Middle            |   | Last  |  | 2a. DATE OF DEATH                 |   | 2b. HOUR                                     |                   |  |
| Carroll   |  |  | G  |   | SPARWASSER, Sr.   |   | 8   |  | Month 30 Day 68 Year              |   | 9:45a M                                      |                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |                   |   | 6. AGE (In years last birthday)                                     |  | IF UNDER 1 YEAR                   |   | IF UNDER 24 HRS.                             |                   |  |
| Male  |  | Caucasian  |  | 4 X/16/28   |                   |   | 40 YRS.   |  | MONTHS DAYS                       |   | HOURS MIN.                                   |                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |   | 9. COUNTY OF DEATH  |  |                                   |   |  |                   |  |
| Maryland  |  | U.S.A.   |  |   |                   |   | Baltimore Md.   |  |                                   |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |                   |  |
| Towson  |  |  | Greater Balto. Med. Center   |   |                   | Clerk   |   |  | Gas & Elec. Co.                   |   |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER            |   |  |                   |  |
| Md.   |  |  | Balto.   |   | Middle River      |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1900 Wilson Pt. Rd.               |   |  |                   |  |
| 14. FATHER'S NAME   |  |  | First  |   | Middle            |   | Last  |  | 15. MOTHER'S MAIDEN NAME          |   |  | First Middle Last |  |
| Edward O. Sparwasser  |  |  |  |   |                   |   |   |  | Caroline L. Petrlick              |   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   |                   | 17. INFORMANT   |   |  |                                   |   |  | Address           |  |
| No  |  |  | 217-22-1767  |   |                   | Margaret A. Sparwasser, 1900 Wilson Pt. Rd.   |   |  |                                   |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |                   |   |   |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| IMMEDIATE CAUSE (a) <u>Hepatic failure</u>  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 200.1 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| (b) <u>Liver metastasis of lymphosarcoma</u>  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| (c) <u>Lymphosarcoma of esophagus</u>   |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 200.1   |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |                   |  |
|   |  |  |  |   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   | YES  |                                   |   |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                   |   |   |  |                                   |   |  |                   |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                   |   |   |  |                                   |   |  |                   |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21, 19 68, to 8/30/68, that (I) (we) last saw the deceased alive on 8/30 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                   |   |   |  |                                   |   |  |                   |  |
| 22b. SIGNATURE  |  |  |  |   |                   |   |   | DEGREE   |                                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| Charles C. Brown, M.D.  |  |  |  |   |                   |   |   |  |                                   |   |  | 8/30/68           |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS  |                   |   |   |  |                                   |   |  |                   |  |
| Charles C. Brown, M.D.  |  |  |  | 6701 N. Charles Street  |                   |   |   |  |                                   |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                   |   |   | 23d. LOCATION (City or Town) (County) (State)                        |                                   |   |  |                   |  |
| Burial  |  | 9-2-68   |  | Druid Ridge   |                   |   |   | Balto., Md.  |                                   |   |  |                   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS   |                   |   |   | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE  |  |                   |  |
| Leonard J. Ruck, Inc., 5305 Harford Rd.   |  |  |  |   |                   |   |   | DATE SEP 3 1968  |                                   | Charles Judge   |  |                   |  |

MEDICAL CERTIFICATION

532



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11246

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11254

|  |  |  |       |   |      |   |  |  |          |  |      |
|--|--|--|-------|---|------|---|--|--|----------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First | Middle  | Last | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR |  |      |
| Wilfred M. Stachnick   |  |  |       |   |      | August 22 1968  |  |  | 7:15 PM  |  |      |
| 3. SEX   |  | 4. RACE  |       | 5. DATE OF BIRTH  |      | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |          | IF UNDER 24 HRS.<br>HOURS MIN.               |      |
| Male   |  | White  |       | 12-19-15  |      | 52 YRS.   |  |  |          |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |          |  |      |
| Maryland   |  | U.S.A.   |       |   |      |   |  |  |          |  |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |          |  |      |
| Towson   |  | St. Joseph Hospital  |       | Customion   |      | P.H.S cho   |  |  |          |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |       | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER   |          |  |      |
| Maryland   |  | Baltimore  |       | Perry Hall  |      |   |  | 4343 Chapel Rd. - 21128  |          |  |      |
| 14. FATHER'S NAME  |  |  | First | Middle  | Last | 15. MOTHER'S MAIDEN NAME  |  |  | First    | Middle                                       | Last |
| Martin C. Stachnick  |  |  |       |   |      | Mary Ruff   |  |  |          |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | (If yes give war or dates of service)  |       | 16b. SOCIAL SECURITY NO.  |      | 17. INFORMANT<br>Address  |  |  |          |  |      |
| Yes  |  | W.W.11   |       | 215-09-6459   |      | Mrs Regina Stachnick 4343 Chapel Road   |  |  |          |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Severe Pulmonary Edema</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |       |   |      |   |  |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u>   |  |  |       |   |      |   |  |  |          |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |          |  |      |
|  |  |  |       |   |      |   |  |  |          |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |  |  |          |  |      |
|  |  |  |       |   |      |   |  |  |          |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)  |       | 21f. LOCATION Street or R.F.D. No.  |      | City or Town  |  | County   |          | State  |      |
|  |  |  |       |   |      |   |  |  |          |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/21/1968</u> , to <u>8/22/1968</u> , that (I) (we) last saw the deceased alive on <u>8/22/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |       |   |      |   |  |  |          |  |      |
| 22b. SIGNATURE<br><u>S. Gaudiel M.D.</u>   |  |  |       |   |      | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>8-22-68</u>                                   |          |  |      |
| 22d. PHYSICIAN'S NAME (Type)<br><u>L. Gaudiel M.D.</u>   |  |  |       |   |      | 22e. ADDRESS<br><u>7620 York Rd., Towson Md., 21204</u>   |  |  |          |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY  |      | 23d. LOCATION (City or Town) (County) (State)   |  |  |          |  |      |
| Burial   |  | 8-26-1968  |       | Gardens of Faith Cem.   |      | Baltimore Co. Md.   |  |  |          |  |      |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |  |       |   |      | 25a. REC'D BY REGISTRAR<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE   |          |  |      |
| Lassahn Funeral Home 7401 Belair Road 21236  |  |  |       |   |      | AUG 26 1968   |  | <u>Charles Judge</u>   |          |  |      |

43071

UNITED STATES DEPARTMENT OF THE INTERIOR

1923

OFFICE OF THE SECRETARY

AUG 2 1923

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |  |   |   |   |   |  |
|--|---------|--|--|--|---|---|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>11247</span> <span>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span>11255</span> </div>   |         |  |  |  |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR                                     |
| JARRETT  |         |  | FRANKLIN   |  |   | STIFLER   |   |   | 3:00 P. M.                                   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD  |  |
| male   | white   | Sept. 26, 1938   | 29 YRS   |  |   |   |   | Month Day Year<br>August 19, 1968   |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |   |  |
| Baltimore, Maryland  |         | U.S.A.   |  |  |   | Baltimore Co., Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Catonsville  |         |  | Spring Grove   |  |   | NONE  |   |   | NONE   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE  |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |
| Maryland   |         |  | Harford  |  | Bel Air   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 111 West Broadway                            |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |   |  |
| First Middle Last<br>William Colburn Stifler, Sr.  |         |  | First Middle Last<br>Mabel Claudia Olivia Hess                               |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT (Mother) 838-7323   |   |   | ADDRESS                                      |
| NO   |         |  | 213-38-7219  |  |   | Mrs. Mabel H. Stifler   |   |   | 111 West Broadway, Bel Air, Maryland 21014   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Death During Epileptic Seizure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>3459<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>3533   |         |  |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br>Werner U. Spitz, M.D.  |         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |   |   | 22b. DATE SIGNED<br>8/20/68                  |
| EXAMINER'S NAME (Type)   |         |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                             |  |   | ADDRESS (Street, city, town, or county)   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |   |  |
| Burial   |         |  | Aug. 23, 1968  |  | Goodwill Meth. Ch. Cem. (Hess Rd.)  |   | Ruthledge Harford Co. Maryland                                      |   |  |
| 24. FUNERAL DIRECTOR<br>Joseph William Foster  |         |  |  |  | ADDRESS<br>W. Broadway & Williams St.<br>Bel Air, Maryland 21014                |   | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 22 1968                      |   | 25b. REGISTRAR'S SIGNATURE                   |

1955

UNITED STATES DEPARTMENT OF AGRICULTURE

4-10

FOR THE  
FARMER



OFFICE OF THE  
DIRECTOR

WASHINGTON, D.C.



1955  
UNITED STATES DEPARTMENT OF AGRICULTURE  
OFFICE OF THE DIRECTOR  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |                   |   |  |                                   |  |  |
|---|--|--|--|---|-------------------|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |                   |   |  |                                   |  |  |
| 11242 CERTIFICATE OF DEATH 11256  |  |  |  |   |                   |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |                   | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| George C. STACH   |  |  |  |   |                   | Month Day Year  |  | 11-5 AM                           |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |                   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| MALE  |  | WHITE  |  | 6-11-87   |                   | 81 YRS.   |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |                                   |  |  |
| BALTO   |  | U.S.A.   |  |   |                   | BALTAMORE Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTO Md.   |  |  | SHAWNSHIRE NURSING HOME  |   |                   | retired   |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| BALTO   |  |  | BALTO  |   | BALTO             |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 5719 Edmondson Ave.                          |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |                   |   |  |                                   |  |  |
| First Middle Last   |  |  | First Middle Last  |   |                   |   |  |                                   |  |  |
| Louis Strohm  |  |  | Katie Lotz   |   |                   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT     |   | Address  |                                   |  |  |
|   |  |  | 218-26-1599A   |   | ELIZABETH PAYNE   |   | 312 Haneslie Rd.   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |                   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |                   |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>   |  |  |  |   |                   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                   |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |                   |   |  |                                   |  |  |
| (b) <u>Arteriosclerotic Cardiovascular Disease</u>  |  |  |  |   |                   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                   |   |  |                                   |  |  |
| (c) <u>Chronic Cardiac Failure</u>  |  |  |  |   |                   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |  |  |   |                   |   |  |                                   |  |  |
| 4330  |  |  |  |   |                   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                                   |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                   |   |  |                                   |  |  |
|   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |                   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |                   |   |  |                                   |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | Street or R.F.D. No. City or Town County State  |                   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>68</u> , to <u>21 Aug</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>21 Aug 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                   |   |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |                   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                  |  |  |
| <u>William J. Bryson</u>  |  |  |  |   |                   |   |  | <u>21 Aug 68</u>                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS  |                   |   |  |                                   |  |  |
| Dr. Bryson  |  |  |  | 4605 Edmondson Ave.   |                   |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial  |  | 8/24/68  |  | Lorrain Cemetery  |                   | Baltimore, Maryland   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS   |                   | 25a. REG'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
| Witzke, 4101 Edmondson Ave., 21229  |  |  |  |   |                   | AUG 26 1968   |  | <u>Francis J. J...</u>            |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |  |   |  |  |  |   |
|---|--|---|--|---|---|--|---|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |  |   |  |  |  |   |
| CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |  |  |  |   |
| 1. DECEASED-NAME<br>(Type or print) <b>ESTHER SUSSMAN</b>   |  |   |  |   |   | 2a. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>7</b> Year <b>1968</b>     |   |  | 2b. HOUR<br><b>4:15 P.M.</b>                   |  |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                  |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MILFORD MANOR NURSING HOME</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                  |  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3805 FORDLEIGH ROAD</b>         |   |
| 14. FATHER'S NAME<br>First <b>UNKNOWN</b> Middle <b></b> Last <b></b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>UNKNOWN</b> Middle <b></b> Last <b></b>  |   |  |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <b>NO</b> (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-9294</b>  |   | 17. INFORMANT<br>Address <b>MR. HARRY SUSSMAN, 11 SLADE AVE., APT. 216</b> |   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>2307 Retropneumonia, type undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>230x</b>  |  |   |  |   |   |  |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>8/7/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/1/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |   |  |   |  |  |  |   |
| 22b. SIGNATURE<br><b>Joseph Shear</b>   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>8/8/68</b>  |   |  |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. JOSEPH SHEAR</b>   |  |   |  | 22e. ADDRESS<br><b>6715 PARK HEIGHTS AVENUE</b>   |   |  |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-9-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |  |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>SOLO LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 9 1968</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |   |

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |   |  |                                |  |
|--|--|--|--------------------------|---|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |   |  |                                |  |
| CERTIFICATE OF DEATH   |  |  |                          |   |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR                       |  |
| ADA  |  |  | B. TABLER                |   |  | 8 Month 17 Day 68 Year  |  | M                              |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| F  |  | W  |                          | 11/16/1883  |  | 84 YRS.   |  | IF UNDER 24 MRS.<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                |  |
| BALTO. Md  |  | U.S.A.   |                          |   |  | BALTIMORE Md.   |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |
| CATONSVILLE  |  | SUMMIT Home  |                          | Housewife   |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER         |  |
| Md   |  | BALTO.   |                          | CATONSVILLE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 10 STANLEY DR.                 |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |   |  |   |  |                                |  |
| First Middle Last  |  |  | First Middle Last        |   |  |   |  |                                |  |
| Charles H. BLACK   |  |  | Elizabeth Shipfuerling   |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |   |  | 17. INFORMANT Address   |  |                                |  |
| NO   |  |  | NONE                     |   |  | WALTER R. TABLER 11 MONTROSE Ave #28  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral-cardiovascular disease</u><br>437.9 DUE TO, OR AS A CONSEQUENCE OF <u>disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>334x</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |                          |   |  |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr + |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Cocaine, it heart</u>   |  |  |                          |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |
|  |  |  |                          |   |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                                |  |
|  |  |  |                          |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State                   |  |
|  |  |  |                          |   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 15, 1955</u> , to <u>Aug. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>8-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                          |   |  |   |  |                                |  |
| 22b. SIGNATURE<br><u>John A. Nesbitt, Jr.</u>  |  |  |                          |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8-19-68  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John A. Nesbitt, Jr., M.D.   |  |  |                          |   | 22e. ADDRESS<br>1009 Frederick Road  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                |  |
| BURIAL   |  | 8/20/68  |                          | MT. OLIVE   |  | RANDALLS TOWN BALTO. Md.  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>E.S. MacNabb 301 Frederick Rd<br>Catonville Md.  |  |  |                          | 25a. REC'D BY REGISTRAR<br>AUG 20 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |                                |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11259

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11259

|  |  |   |                       |   |  |   |   |
|--|--|---|-----------------------|---|--|---|---|
| 1. DECEASED NAME<br>(Type or print)<br><b>Vincenza</b><br><b>Margina</b>   |  | First<br><b>Vincenza</b>  | Middle<br><b>(NM)</b> | Last<br><b>Tallarico</b>  | 2c. DATE OF DEATH<br>Month <b>8</b> Day <b>31</b> Year <b>1968</b> |   | 2b. HOUR<br><b>7:24</b> P.M.                                |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |                       | 5. DATE OF BIRTH<br><b>April 22, 1885</b>   |  | 6. AGE (In years last birthday)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b>  |                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |                       | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>First <b>Bruno</b> Middle <b>Anania</b> Last <b>Marianna</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Marianna</b> Middle <b>?</b> Last <b>?</b>   |                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no (or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mr John Tallarico</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain hemorrhage</b><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>331X</b>   |  |   |                       |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/31/</b> 19 <b>68</b> , to <b>8/31/6</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/31/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                       |   |  |   |   |
| 22b. SIGNATURE<br><b>Ines Cilliani</b>   |  | DEGREE  |                       | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>9/1/68</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |                       |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/4/68</b>  |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc</b>  |  | ADDRESS<br><b>Baltimore, Md</b>   |                       | 25a. REC'D BY REGISTRAR<br><b>SEP 3 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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1950-1951, 1952-1953, 1954-1955, 1956-1957, 1958-1959, 1960-1961, 1962-1963, 1964-1965, 1966-1967, 1968-1969, 1970-1971, 1972-1973, 1974-1975, 1976-1977, 1978-1979, 1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 2688-2689, 2690-2691, 2692-2693, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11252

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11260

CERTIFICATE OF DEATH

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES W TAWNEY</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>30</b> Year <b>68</b>                                   |   |  | 2b. HOUR<br><b>3:17 A M</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>4/23/1893</b>  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Gen. Supt. Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Rodgers Forge</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>308 Dunkirk Rd.</b>  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>First <b>Charles H.</b> Middle <b>Tawney</b> Last <b>Charles H. Tawney</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Nettie M.</b> Middle <b>Uhler</b> Last <b>Nettie M. Uhler</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212 10 9071</b>   |  | 17. INFORMANT<br>Address <b>Pearl A. Tawney 308 Dunkirk Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Heart failure &amp; pulmonary edema</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 min</b><br><b>10 year</b><br><b>1 1/2 hours</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4330</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19____, to <b>8/30, 1968</b> , that (I) (we) lost the deceased alive on <b>8/30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. H. Townsend M.D.</b> DEGREE<br><b>W. H. TOWNSEND</b>  |  |  |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (Type) <b>W. H. TOWNSEND</b>   |  |
| 22e. ADDRESS<br><b>14 E. EAGER ST BALTO, MD</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/3/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Meth. Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Falls Rd. Balto. Md.</b>                 |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Mitchell Wiedefeld Home 6500 York Rd.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |

1581

3. *Principles of the Law of the Sea*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11253  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11261  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | P M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Glenn I. Taylor  |  |  |  |  |  |  |  |  |  | August 31 1968   |  |  |  |  |  |  |  |  |  | 10:30  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| Male   |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | Feb., 21, 1897   |  |  |  |  |  |  |  |  |  | 71 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Pennsylvania   |  |  |  |  |  |  |  |  |  | United States  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Towson   |  |  |  |  |  |  |  |  |  | St. Joseph's Hospital  |  |  |  |  |  |  |  |  |  | Retired  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Washington, D.C.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Washington D.C.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1820 23rd St., Southeast    |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| George A Taylor  |  |  |  |  |  |  |  |  |  | Eugena Manley  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Garie G Taylor   |  |  |  |  |  |  |  |  |  | 1820 23rd St S.E   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | Intracranial Hemorrhage  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4319   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 331X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | City or Town County State  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 20, 1968, to August 31, 1968, that (I) (we) lost the deceased alive on 8/31/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 9-1-68   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Ismael O. Jamora M.D.  |  |  |  |  |  |  |  |  |  | 7620 York Rd. Towson, Md. 21204  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 9/4/68   |  |  |  |  |  |  |  |  |  | Fort Lincoln Cemetery  |  |  |  |  |  |  |  |  |  | Colmar, Manor Maryland   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Lee Funeral Home   |  |  |  |  |  |  |  |  |  | 300 4th St ne. Washington, D.C.  |  |  |  |  |  |  |  |  |  | DATE SEP 6 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

11351

OFFICE OF THE SECRETARY

11351

TO: THE SECRETARY, ARMY AND NAVY DEPARTMENT, WASHINGTON, D.C.

FROM: THE SECRETARY, ARMY AND NAVY DEPARTMENT, WASHINGTON, D.C.

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

REMARKS: [Illegible]

RECOMMENDATION: [Illegible]

APPROVED: [Illegible]

SIGNED: [Illegible]

COPIES: [Illegible]

NOTES: [Illegible]

ADDITIONAL INFORMATION: [Illegible]

ADMINISTRATIVE: [Illegible]

LEGAL: [Illegible]

FINANCIAL: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

REMARKS: [Illegible]

REMARKS: [Illegible]

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>RAYMOND</b>   |  | First <b>J.</b>  |  | Middle  |  | Last <b>Tegeler</b>   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> Month <b>Aug</b> Day <b>30</b> Year <b>1968</b> |  | 2b. HOUR<br><b>7:15</b> M                        |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>12-15-09</b>   |  | 6. AGE (In years last birthday)<br><b>58</b> YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hosp.</b>   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Security</b>     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  |  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 13e. STREET AND NUMBER<br><b>608 WALKER AVE.</b> |  |
| 14. FATHER'S NAME<br>First <b>Albert</b> Middle <b>Tegeler</b> Last <b>Tegeler</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Rosa</b> Middle <b>Steele</b> Last <b>Steele</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.V. 2 214-18-5814</b>   |  | 17. INFORMANT<br><b>Viola M. Tegeler</b>  |  |  |  | ADDRESS<br><b>same</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M.   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>William A. Pillsbury</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED<br><b>8-30-68</b>   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>William A. Pillsbury</b>  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  | ADDRESS (Street, City, and County)<br><b>Towson, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/3/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore, National</b>  |  |   |  | 23d. LOCATION (City or Town)<br><b>Balto. Md.</b> (County) (State)   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Balto. Md.</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 3 1968</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>  |  |  |  |

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## CERTIFICATE OF DEATH

11263

|  |  |  |   |   |   |  |   |   |                             |                                |
|--|--|--|---|---|---|--|---|---|-----------------------------|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First   | Middle  | Lost  | 2a. DATE OF DEATH<br>Month Day Year  |   |   | 2b. HOUR<br>10:15 A.M.      |                                |
| Joseph Terracina   |  |  |   |   |   | August 20, 1968  |   |   |                             |                                |
| 3. SEX<br>M  |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>November 18, 1889   |   | 6. AGE (In years last birthday)<br>78 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                      |                             | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |   |                             |                                |
| 10. CITY OR TOWN OF DEATH<br>Catonsville, Md   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>5627 Johnnycake Road |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Mechanic   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Penna R.R   |   |   |                             |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Catonsville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |   | 13e. STREET AND NUMBER<br>5627 Johnnycake Rd. 21207 |                             |                                |
| 14. FATHER'S NAME<br>First Middle Last<br>Joseph Terracina (deceased)  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Rose (deceased)              |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>no |   |   |                             |                                |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br>Address<br>21207<br>Mrs Maria Terracina, 5627 Johnnycake Rd. |   |   |  |   |   |                             |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>chronic (myocardial) failure</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |  |   |   |                             |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200   |  |  |   |   |   |  |   |   |                             |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |   |                             |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |  |   |   |                             |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County State                |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1968</u> , to <u>Aug. 20, 1968</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>8/19</u> 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.    |  |  |   |   |   |  |   |   |                             |                                |
| 22b. SIGNATURE<br>Joseph R. Liberto, M.D.  |  |  |   |   | DEGREE<br>ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8/20/68 |                                |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Joseph Liberto   |  |  |   |   | 22e. ADDRESS<br>3508 13th St - Baltimore, Md 21224                              |  |   |   |                             |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8/24/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland   |   |   |                             |                                |
| 24. FUNERAL DIRECTOR<br>Witzke, 4101 Edmondson Ave., 21229   |  |  |   |   | 25a. REC'D BY REGISTRAR<br>AUG 21 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                 |   |                             |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11256

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11264

CERTIFICATE OF DEATH

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Goldie Louise Thomas</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>12</b> Year <b>1968</b>                      |   |  | 2b. HOUR<br><b>11:45 A.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br><b>12-8-28</b>  |  | 6. AGE (In years, last birthday)<br><b>39</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |  |  |  |
| 1d. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mount Wilson St. Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN<br><b>city</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>718 W. Mulberry St.</b>               |  |
| 14. FATHER'S NAME<br>First <b>Paul</b> Middle <b>Tennessee</b> Last <b>Katherine Taylor</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Katherine</b> Middle <b>Taylor</b> Last <b>Taylor</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-7531</b>  |  | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>  |  | Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY FIBROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRONCHIECTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TUBERCULOSIS, PULMONARY, ACUTE + CHRONIC.</b><br>011.9                    |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br>002.1  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9, 1965</b> , to <b>Aug. 12, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. Newcomer</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8-12-68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>   |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 23b. DATE<br><b>8-17-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>mt. auburn</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore md</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>William M. C. C. C.</b>  |  | 24a. ADDRESS<br><b>1111 N. ...</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 13 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

CONTRACT

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 11257 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11265

|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First<br>HENRY   |  |  | Middle<br>ROBERT  |  |  | Last<br>THOMAS  |  |  | 2a. DATE KNOWN OF DEATH                                     |  |  | 2b. HOUR                                |  |  |
| 3. SEX<br>MALE   |  |  | 4. RACE<br>CAU.  |  |  | 5. DATE OF BIRTH<br>April 4, 1918   |  |  | 6. AGE (In years last birthday)<br>50 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                           |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.       |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Pa.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Balto.  |  |  | 2c. DATE PRONOUNCED DEAD<br>Month 8 Day 15 Year 1968        |  |  | 2d. HOUR<br>5 P.M.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Timonium  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Md. State Fair Grounds |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Cook   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Rest.  |  |  |   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Pa.   |  |  | 13b. COUNTY<br>Adams   |  |  | 13c. CITY OR TOWN<br>Gettysburg   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>317 Buford Ave.                   |  |  |   |  |  |
| 14. FATHER'S NAME<br>First<br>Wilber   |  |  | Middle<br>G.   |  |  | Last<br>Thomas  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Minnie   |  |  | Middle<br>Wolfe   |  |  | Last                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes   |  |  | (If yes give war or dates of service)<br>WW II   |  |  | 16b. SOCIAL SECURITY NO.<br>205-10-2764   |  |  | 17. INFORMANT<br>Minnie Thomas  |  |  | ADDRESS<br>Same as Above                                    |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden      |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |  |   |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |  |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town  |  |  | County  |  |  | State                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| ACTUAL EXAMINER'S NAME (Type)<br>Charles F. O'Donnell, M.D.  |  |  | 22b. DATE SIGNED<br>8/13/68  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  | ADDRESS (Street, city, town, or county) |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>8-20-1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>National Cem.   |  |  | 23d. LOCATION (City or Town)<br>Gettysburg, Pa.   |  |  | (County)  |  |  | (State)                                 |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks, Inc.  |  |  | 1217 St. Paul St.<br>Balto., Md. 21202   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>AUG 19 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |   |  |  |   |  |  |

11785

FROM: EXAMINER, CHAIRMAN OF BOARD

10-1-1900

10-1-1900

Correspondence

8/10/02

Charles F. Thomas

AUG 10 1902



11258

## CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>LOUIS S. THOMAS</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>20</b> Year <b>1968</b>                                    |   |  | 2b. HOUR<br><b>6:15</b>  |  |   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>                    |  | 5. DATE OF BIRTH<br><b>APRIL 1, 1895</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>LEBANON</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Realtor</b>                              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>              |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1316 GLENMONT RD. #21212</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Tandus Shalhaur</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Diamond (?)</b>   |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT Address<br><b>Mrs. Lena S. Thomas-1316 Glenmont Rd. 12</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 4</b> , 19 <b>68</b> , to <b>August 20</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>August 20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Luis Renjel</i>   |  |  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>Aug. 20, 1968</b>                             |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Luis Renjel, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>8/23/68</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto</b>        |   |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 26 1968</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11259

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11267

|  |  |  |  |   |  |   |  |   |                                       |                      |  |  |  |                       |  |
|--|--|--|--|---|--|---|--|---|---------------------------------------|----------------------|--|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>Baby Girl</b>  |  | First<br><b>Thompson</b>   |  | Middle<br><b>Thompson</b>   |  | Last<br><b>Thompson</b>   |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>18</b> Year <b>1968</b> |                                       |                      | 2b. HOUR<br><b>1:45</b> P.M.               |  |  |                       |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 18, 1968</b>  |  |   | 6. AGE (In years last birthday)<br><b>Nb.</b> YRS.                   |   | IF UNDER 1 YEAR<br>MONTHS<br><b>2</b> |                      | IF UNDER 24 HRS.<br>HOURS<br><b>2</b> MIN. |  |  |                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |   |                                       |                      |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>N/A.</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |                                       |                      |  |  |  |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>145 Hollow Brook Rd.</b>                   |                                       |                      |  |  |  |                       |  |
| 14. FATHER'S NAME<br><b>Charles Jeffrey Thompson</b>   |  | First<br><b>Charles</b>  |  | Middle<br><b>Jeffrey</b>  |  | Last<br><b>Thompson</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary Kathleen Horton</b>                 |                                       | First<br><b>Mary</b> |  | Middle<br><b>Kathleen</b>                    |  | Last<br><b>Horton</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br>Address  |  |   |  |   |                                       |                      |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Congenital Anomalies</b><br><b>7599</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |                                       |                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1593</b>  |  |  |  |   |  |   |  |   |                                       |                      |  |  |  |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                       |                      |  |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |   |  |   |                                       |                      |  |  |  |                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |                                       |                      |  |  |  |                       |  |
| 22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>8/18/</b> 19 <b>68</b> , to <b>8/18/</b> 19 <b>68</b> , that <b>01</b> (we) last saw the deceased alive on <b>8/18/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |   |  |   |                                       |                      |  |  |  |                       |  |
| 22b. SIGNATURE<br><b>Lawrence F. Misanik</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>8/20/68</b>  |  |   |                                       |                      |  |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LAWRENCE F. MISANIK M.D.</b>  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |   |  |   |  |   |                                       |                      |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8.23.68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>U of Md. Med. School</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |   |                                       |                      |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 28 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |                                       |                      |  |  |  |                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11260  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 11268                       |  |  |  |  |                            |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|----------------------------|--|--|--|--|
| Item 11 tel.conv.with hosp.8/27/68   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| LAURENCE P.  |  |  |  |  | TIMANUS  |  |  |  |  | 8 21 68  |  |  |  |  | 2:35P M   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |
| Male   |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | 74 YRS.   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| MARYLAND   |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  | Md.                         |  |  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during majority of working life, even if retired)   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Baltimore, Md.   |  |  |  |  | St. Joseph's Hospital  |  |  |  |  | Pres. Sales-ret. Paper Co.   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. CITY OR TOWN  |  |  |  |  | 13c. INSIDE CITY LIMITS?   |  |  |  |  | 13e. STREET AND NUMBER  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Md. Towson   |  |  |  |  | Baltimore  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 548 Hampton Lane  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Charles S. Timanus   |  |  |  |  | Florence George  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| No   |  |  |  |  | None   |  |  |  |  | 213-01-8790  |  |  |  |  | Family records  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| IMMEDIATE CAUSE (a) Extensive carcinoma of the left colon with   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 153.2 DUE TO, OR AS A CONSEQUENCE OF obstruction and massive pulmonary   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| (b) metastases   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 153.2  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 8/14/68  |  |  |  |  | Ca. of lt. colon with obstruction  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | Yes   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
|  |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
|  |  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION  |  |  |  |  | City or Town County State   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/5/1968, to 8/21/1968, that (I) (we) last saw the deceased alive on 8/21/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED            |  |  |  |  |                            |  |  |  |  |
| Rudiger Breiteneker, M.D.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 8/22/68                     |  |  |  |  |                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Rudiger Breiteneker, M.D.  |  |  |  |  |  |  |  |  |  | Greater Baltimore Medical Center   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| Burial   |  |  |  |  | Aug. 24, 1968  |  |  |  |  | Ansel Hill Cemetery  |  |  |  |  | Harve de Grace, Maryland  |  |  |  |  |                             |  |  |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                            |  |  |  |  |
| John Burns Sons  |  |  |  |  |  |  |  |  |  | Towson, Md.  |  |  |  |  | DATE AUG 26 1968  |  |  |  |  | Charles Judge               |  |  |  |  |                            |  |  |  |  |

83311

1943

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 2 and page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11269   |  |  |                              |  |  |  |  |  |                                 | 11269   |  |                 |  |  |  |                            |  |  |  |  |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------|--|--|--|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                              |  |  |  |  |  |                                 | CERTIFICATE OF DEATH  |  |                 |  |  |  |                            |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |                              |  | First Middle Lost  |  |  |  |                                 | 2a. DATE OF DEATH<br>Month Day Year   |  |                 |  |  | 2b. HOUR   |                            |  |  |  |  |
| Joseph  |  |  |                              |  | E  |  |  |  |                                 | Vettor  |  |                 |  |  | August 22 1968 5:55 PM   |                            |  |  |  |  |
| 3. SEX  |  |  | 4. RACE                      |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday) |   |  | IF UNDER 1 YEAR |  |  | IF UNDER 24 HRS.   |                            |  |  |  |  |
| Male  |  |  | White                        |  |  | 2-10-1888  |  |  | 80 YRS.                         |   |  | MONTHS          |  |  | DAYS   |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH              |   |  |                 |  |  |  |                            |  |  |  |  |
| Italy   |  |  | U.S.A.                       |  |  |  |  |  | Baltimore Md.                   |   |  |                 |  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                            |  |  |  |  |
| Towson  |  |  |                              |  | St. Joseph Hospital  |  |  |  |                                 | STONE MASON   |  |                 |  |  | BUILDING   |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |                              |  | 13b. COUNTY  |  |  |  |                                 | 13c. CITY OR TOWN   |  |                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER     |  |  |  |  |
| Maryland  |  |  |                              |  |  |  |  |  |                                 | Baltimore   |  |                 |  |  |  | 3101 Rueckert Ave., -21214 |  |  |  |  |
| 14. FATHER'S NAME   |  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| First Middle Lost   |  |  |                              |  | First Middle Lost  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| MAURICE   |  |  |                              |  | VETTOR   |  |  |  |                                 | DOROTHY   |  |                 |  |  | GISTON   |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |  |  |                                 | 17. INFORMANT   |  |                 |  |  | Address  |                            |  |  |  |  |
| NO  |  |  |                              |  | 206-10-0258A   |  |  |  |                                 | YOLANDA MATASSA   |  |                 |  |  | 2815 Second Ave  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                            |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u>  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| 491X DUE TO, OR AS A CONSEQUENCE OF   |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| (b) <u>Chronic recurrent bronchitis and severe</u>  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| (c) <u>pulmonary Emphysema</u>  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| 5020  |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                 |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |                 |  |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |                 |  |  |  |                            |  |  |  |  |
|   |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19/68</u> , 19 <u>68</u> , to <u>8/22/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/22/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                              |  |  |  |  |  |                                 |   |  |                 |  |  |  |                            |  |  |  |  |
| 22b. SIGNATURE <u>Nieva G. Valle, MD</u> DEGREE   |  |  |                              |  |  |  |  |  |                                 | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |                 |  |  | 22c. DATE SIGNED <u>8/22/68.</u>                                     |                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Nieva G. Valle MD</u>   |  |  |                              |  |  |  |  |  |                                 | 22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>  |  |                 |  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)   |  |  |                              |  | 23b. DATE <u>8/26/68</u>   |  |  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>   |  |                 |  |  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>    |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>C. F. EVANS + Son</u> ADDRESS <u>8802 Harford Rd.</u>   |  |  |                              |  |  |  |  |  |                                 | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 26 1968</u>  |  |                 |  |  | 25b. REGISTRAR'S SIGNATURE   |                            |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in many event, within 72 hours after death.

|   |  |  |   |   |               |  |  |
|---|--|--|---|---|---------------|--|--|
| 11262   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |   |   |               | 11270  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |               |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>HOWARD O. WALBECK</b>   |  |  | 2a. DATE OF DEATH<br>8 Month 23 Day 68 Year |   | 2b. HOUR<br>M |  |  |
| 3. SEX<br><b>m</b>  |  | 4. RACE<br><b>w</b>  |   | 5. DATE OF BIRTH<br><b>6/7/81</b>   |               | 6. AGE (In years last birthday)<br><b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. COUNTY OF DEATH<br><b>BALTO.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOUSE IN PINE</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SALESMAN</b>  |               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PET.</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>HERMAN WALBECK</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   | 13e. STREET AND NUMBER<br><b>500 ACADEMY RD.</b>  |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-3274</b>   |   | 17. INFORMANT<br><b>EDW. WALBECK</b>  |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEUTE UNPENDING INVESTIGATION</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO-SCLEROTIC CHANGING VASCULAR DISEASE</b> |  |  |   |   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |  |  |   |   |               |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1, 1960</b> , to <b>8/23, 1968</b> , that (I) (we) last saw the deceased alive on <b>8/23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |               |  |  |
| 22b. SIGNATURE<br><b>John H. Shaw M.D.</b>  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |               | 22c. DATE SIGNED<br><b>8/24/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John H. Shaw</b>   |  |  |   | 22e. ADDRESS<br><b>5805 EMBLETTON AVE ANN-18-10</b>   |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8/26/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN</b>   |               | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO CO MD</b>                          |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. MALNABR 21228</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 26 1968</b>   |               | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

COLLIER-PHOTO

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| Item 7b Film G401 8-7168 W   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| 11263  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| 11271  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>Margaret   |  |  | Middle<br>Veronica  |  |  | Last<br>WALSH   |  |  | 2a. DATE OF DEATH<br>August 23 1968            |  |  | 2b. HOUR<br>M                  |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Cauc.  |  |  | 5. DATE OF BIRTH<br>November 25, 1875   |  |  | 6. AGE (in years last birthday)<br>92 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                 |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Ireland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1001 West Joppa Rd. |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Nun  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Teacher  |  |  |  |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore  |  |  | 13c. CITY OR TOWN<br>Towson   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>1001 West Joppa Road |  |  |                                |  |  |
| 14. FATHER'S NAME<br>First<br>Anthony  |  |  | Middle<br>Walsh   |  |  | Last<br>Ann   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Boyle  |  |  | Middle<br>Boyle                                |  |  | Last<br>Boyle                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>No   |  |  | (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>1001 West Joppa Road<br>Mission Helpers of the Sacred Heart                    |  |  |  |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |                                |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| IMMEDIATE CAUSE (a)<br>4120<br>Pneumonia   |  |  |   |  |  |   |  |  |   |  |  | 24 hrs   |  |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Pneumonia   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)<br>Cardio-renal vascular disease   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>442x   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 to 23 August 1968, that (I) last saw the deceased alive on 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                                |  |  |
| 22b. SIGNATURE<br>Charles F. O'Donnell   |  |  | 22c. DATE SIGNED<br>8/26/68   |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Charles F. O'Donnell  |  |  | 22e. ADDRESS<br>7501 York Rd. Baltimore, Md 21204   |  |  |  |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>Aug. 26, 1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Convent Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Baltimore, Maryland                    |  |  |  |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br>J. E. Lowell Lemmon  |  |  | 4611 Park Heights Ave,  |  |  | 25a. REC'D BY REGISTRAR<br>AUG 29 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |  |                                |  |  |

11371

1933

August 29

Winnipeg

Manitoba

Canada

November 2, 1933

Winnipeg

Winnipeg

Manitoba

1931 West Coast Road

Winnipeg

1931 West Coast Road

Winnipeg

Manitoba

1931

Manitoba

Winnipeg

Canada

1931 West Coast Road

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Winnipeg

Charles F. O'Donnell

1931 West Coast Road

Winnipeg

Manitoba

Canada

1931

Manitoba

Canada



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

11264

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11272

CERTIFICATE OF DEATH

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Roy Edward Walsh</b>  |   |   | 2a. DATE OF DEATH<br>8 Month 5 Day 68 Year  |   | 2b. HOUR<br>8:33pM   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cau</b>   | 5. DATE OF BIRTH<br><b>5/29/20</b>  |   | 6. AGE (In years last birthday)<br><b>48</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Center</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Real State</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real State</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Talbot</b>  | 13c. CITY OR TOWN<br><b>Easton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Roy Walsh</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Bessie Rodier</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>Yes</b>  | (If yes give war or dates of service)<br><b>WW II</b>   | 16b. SOCIAL SECURITY NO.<br><b>140-14-1709</b><br><b>215-24-7647</b>  | 17. INFORMANT Address<br><b>MR. ROY E. WALSH EASTON MD</b>                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute compression and necrosis of high cervical</b> 24 hrs<br><b>1419</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>spinal cord</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic squamous cell carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Primary squamous cell carcinoma of tongue</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1419 Diabetes mellitus</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/14</b> , 19 <b>68</b> , to <b>8/5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Charles C. Brown, M.D.</b>   |   |   | DEGREE<br><b>M.D.</b>   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>8/5/68</b>                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles C. Brown, M.D.</b>   |   |   | 22e. ADDRESS<br><b>6701 N. Charles Street</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>8-8-1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Wye Church Yard</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Wye Mills, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Wye Mills</b>  |   | ADDRESS<br><b>Easton Md</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 8 1968</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |

1. The first part of the report is a summary of the work done during the period.

2. The second part is a detailed account of the work done during the period.

3. The third part is a summary of the work done during the period.

4. The fourth part is a detailed account of the work done during the period.

5. The fifth part is a summary of the work done during the period.

6. The sixth part is a detailed account of the work done during the period.

7. The seventh part is a summary of the work done during the period.

8. The eighth part is a detailed account of the work done during the period.

9. The ninth part is a summary of the work done during the period.

10. The tenth part is a detailed account of the work done during the period.

11. The eleventh part is a summary of the work done during the period.

12. The twelfth part is a detailed account of the work done during the period.

13. The thirteenth part is a summary of the work done during the period.

14. The fourteenth part is a detailed account of the work done during the period.

15. The fifteenth part is a summary of the work done during the period.

16. The sixteenth part is a detailed account of the work done during the period.

17. The seventeenth part is a summary of the work done during the period.

18. The eighteenth part is a detailed account of the work done during the period.

19. The nineteenth part is a summary of the work done during the period.

20. The twentieth part is a detailed account of the work done during the period.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |  |  |  |  |                           |  |  |
|---|--|---|--|--|--|--|--|--|---------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |  |                           |  |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |                           |  |  |
| 1. DECEASED-NAME (Type or print) <b>JAMES ERNEST WALTON</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>20</b> Year <b>1968</b>                      |  |  | 2b. HOUR <b>3:45</b> A.M. |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>2/10/20</b>   |  | 6. AGE (In years last birthday)<br><b>48</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                           | IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  | Md.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Adm. Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Construction</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractors.</b> |  |                           |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>114 S. Patterson Pk Ave.</b>            |                           |  |  |
| 14. FATHER'S NAME First <b>Jasper</b> Middle <b>Walton</b> Last <b>Sallie Bolen</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Sallie Bolen</b> Middle <b>Walton</b> Last <b>Sallie Bolen</b>   |  |  |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b>   |  | (If yes give war or dates of service) <b>WW-11</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>228 10 78 96</b>  |  | 17. INFORMANT Address<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>                 |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LUNGS WITH METASTASIS,</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF <b>POSTOPERATIVE.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |   |  |  |  |  |  |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163x</b>   |  |   |  |  |  |  |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                           |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |                           |  |  |
| 22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Aug. 2</b> , 19 <b>68</b> , to <b>Aug. 20</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Aug. 20</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |  |  |  |  |  |                           |  |  |
| 22b. SIGNATURE<br><i>George C. McElPatrick</i>  |  | DEGREE<br><b>GEORGE C. McELPATRICK, M.D.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>8/20/68</b>   |  |  |                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GEORGE C. McELPATRICK, M.D.</b>  |  | 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>  |  |  |  |  |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 23, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sherwood Mem. Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salem, Virginia</b>                      |  |  |                           |  |  |
| 24. FUNERAL DIRECTOR<br><i>Patterson Funeral Home</i>   |  | ADDRESS<br><b>Perryville, Md.</b>   |  | REC'D BY REGISTRAR<br><b>AUG 27 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |                           |  |  |

STATE OF TEXAS

1908

County of \_\_\_\_\_ State of Texas

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of Texas

do hereby certify that \_\_\_\_\_

is the true and correct owner of \_\_\_\_\_

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |   |  |  |  |                               |
|--|--|--|--|---|--|--|--|---|--|--|--|-------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |   |  |  |  |                               |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |  |  |                               |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>LORETTA</b>                                |   |  | Middle<br><b>WARD</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>3</b> Year <b>1968</b> |  |  | 2b. HOUR a.<br><b>12:30 M</b> |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>DECEMBER 18, 1883</b>  |  |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN                |                               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |   |  |  |  |                               |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON 4</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSE WIFE</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>      |  |  |  |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. CITY<br><b>BALTIMORE 4</b>  |  | 13c. CITY OR TOWN<br><b>TOWSON</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>505 W. CHESAPEAKE AVE #4</b> |  |  |  |                               |
| 14. FATHER'S NAME First Middle Last<br><b>MATTHEW OSBOURNE</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>—</b> |   |  |  |  |   |  |  |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>Family Records</b>  |  |  | Address  |   |  |  |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gram-negative Septicemia</b><br><b>038.8</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                   |  |  |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>0533</b>   |  |  |  |   |  |  |  |   |  |  |  |                               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |  |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |   |  |  |  |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |                               |
| 22a. I certify that <del>it</del> (this hospital) attended the deceased from <b>July 31</b> , 19 <b>68</b> , to <b>August 3</b> , 19 <b>68</b> , that (I) <del>we</del> saw the deceased alive on <b>August 3</b> , 19 <b>68</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death. |  |  |  |   |  |  |  |   |  |  |  |                               |
| 22b. SIGNATURE<br><b>Lilia a. Baldonado</b>  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>August 3, 1968</b>  |  |   |  |  |  |                               |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lilia Baldonado, M. D.</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Road, Towson 4, Maryland</b>   |  |  |  |   |  |  |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>Aug. 6, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. MARIE CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>TOWSON, Md.</b>                          |  |   |  |  |  |                               |
| 24. FUNERAL DIRECTOR<br><b>John Burns Sons, Towson, Md.</b>  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>        |  |  |  |                               |

MEDICAL CERTIFICATION

11874

11874

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

TO THE DIRECTOR  
FROM THE CHIEF OF BUREAU  
SUBJECT: [illegible]

[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which may be headings or subheadings, but the specific content cannot be accurately transcribed.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |  |  |  |
| 11267   |  |  |   |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |  |  |
| 11275   |  |  |   |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>GILBERT</b>   |  |  | Middle<br><b>WILLIAM</b>  |  |  | Last<br><b>WATKINS</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>NEGRO</b>   |  |  | 5. DATE OF BIRTH<br><b>5/13/92</b>  |  |  | 2a. DATE OF DEATH<br>Month<br><b>AUGUST</b> Day<br><b>1</b> Year<br><b>1968</b>              |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>CALVERT CO. MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>JANITOR</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MILTON SWARTZ CO</b>                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First<br><b>WILLIAM</b>  |  |  | Middle<br><b>WATKINS</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>ISABELLA</b>  |  |  | Middle<br><b>HARRIS</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>   |  |  | 17. INFORMANT<br>Address<br><b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>157.9</b> <b>TERMINAL CARCINOMA OF PANCREAS WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)<br><b>157.9</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7/10/68</b> , 19__, to <b>8/1/68</b> , 19__, that (1) (we) last saw the deceased alive on <b>8/1/68</b> , 19__, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>George C. McElfatrick</i>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  | 22c. DATE SIGNED<br><b>8/1/68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GEORGE C. MC ELFATRICK, M. D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>Aug. 7, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Joseph L. Russ</i>   |  |  |   |  |  | ADDRESS<br><b>JOSEPH L. RUSS FUNERAL HOME</b>   |  |  | 25a. RECORDING REGISTRAR<br>DATE<br><b>1968</b>  |  |  |
|   |  |  |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |

1575

UNITED STATES OF AMERICA

1968

AMOUNT OF \$100.00 PAID TO THE UNITED STATES OF AMERICA

ON BEHALF OF THE UNITED STATES OF AMERICA

FOR THE YEAR ENDING 1967

IN FULL PAYMENT OF THE DEBT

TO THE UNITED STATES OF AMERICA

FOR THE YEAR ENDING 1967

IN FULL PAYMENT OF THE DEBT

TO THE UNITED STATES OF AMERICA

FOR THE YEAR ENDING 1967

IN FULL PAYMENT OF THE DEBT

TO THE UNITED STATES OF AMERICA

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TO THE UNITED STATES OF AMERICA

FOR THE YEAR ENDING 1967

IN FULL PAYMENT OF THE DEBT

TO THE UNITED STATES OF AMERICA

FOR THE YEAR ENDING 1967

IN FULL PAYMENT OF THE DEBT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  |
| 11268   |  |  |  |   |   |   |  |  |  |
| 11276   |  |  |  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |
| Frank   |  |  | L. Werneth   |   |   | 8 30 1968   |  |  | 11:16 AM                                     |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)                                      |  | 7. IF UNDER 1 YEAR                           |
| Male  |  | White  |  | Feb. 7, 1889  |   |   | 79 YRS.  |  | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH   |  |  |
| Maryland  |  | United States  |  |   |   |   | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson  |  |  | St. Joseph's Hospital  |   |   | Retired Salesman  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER                       |
| Maryland  |  |  | Baltimore  |   | Baltimore   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 8427 Loch Raven Blvd.                        |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |  |  |
| John Joseph Wreneth   |  |  | Lizzie Kohlepp   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address  |  |  |
| No  |  |  | 215-09-0306  |   | Helen N Werneth   |   | Same   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intestinal infarction</u><br><u>444.2</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>570.2</u>  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |  |
|   |  |  |  |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 30</u> , 19 <u>68</u> , to <u>Aug. 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Ines Cilliani</u>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>August 31, 1968</u>         |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Ines Cilliani, M. D.</u>   |  |  |  |   |   | 22e. ADDRESS<br><u>7620 York Rd. Towson, Md. 21204</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| <u>Burial</u>   |  | <u>9/3/68</u>  |  | <u>Parkwood</u>   |   | <u>Baltimore, Md</u>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Leonard J Ruck INC</u>   |  |  |  | ADDRESS<br><u>Baltimore, Md</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 3 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |

1:11

1:11

1331

x

to

le

1331

x

11263

## CERTIFICATE OF DEATH

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Irvin Edwin Wheeler   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>August 15 1968 |   |  | 2b. HOUR<br>11:19 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cau  |   | 5. DATE OF BIRTH<br>Sept. 26, 1893  |  | 6. AGE (In years last birthday)<br>74 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balt. Co. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore County Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>Upperco   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Mt. Carmel Road |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Farmer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Farming  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Upperco  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>Mt. Carmel Road  |  | 14. FATHER'S NAME First Middle Last<br>Joshua M Wheeler   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Rachel J. Hare  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) Yes   |  | (If yes give war or dates of service)<br>W.W. 1   |   | 16b. SOCIAL SECURITY NO.<br>220-34-6046   |  | 17. INFORMANT<br>Gertie J. Wheeler  |  |
| 16c. ADDRESS<br>Mt. Carmel Rd. Upperco, Md.  |  |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Bronchitis - Pneumonia</u><br>342X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Paralysis Agitans</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>15 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>350X  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from June 1950, to Aug 15, 1968, that (1) (we) lost saw the deceased alive on Aug 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>Maurice C. Porterfield M.D.  |  |   |   | 22c. DATE SIGNED<br>8-16-68   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>M.C. Potterfield MD  |  |   |   | 22e. ADDRESS<br>28 S. Main St. Hampstead, Md 21074  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>8/18/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Grace United M.E. Cem.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Hampstead, Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>John E. Goff   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE AUG 23 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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James Buchanan  
James Buchanan

James Buchanan  
James Buchanan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| <div>11270</div> <div>11278</div> <div>CERTIFICATE OF DEATH</div>  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| MARY   |  |  | LOUISE WHITAKER.   |  |  | 8 <sup>Month</sup> 18 <sup>Day</sup> 1968 <sup>Year</sup>                               |  | 5-A M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                      |  |
| FEMALE   |  | WHITE  |  | Oct 29 <sup>1877</sup> 1898 <sup>99</sup>  |  | 99 YRS.   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |
| VIRGINIA   |  | USA  |  |  |  | BALTIMORE Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| COCKEYSVILLE   |  |  | MARYLAND MASONIC HOME  |  |  | CHURCH SEC.   |  | CHURCH   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| MD. COLLEGE (BALLO) MANOR  |  |  | TOWSON   |  |  | COLLEGE MANOR   |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |  |  |
| SAMUEL DEXTER FULLER   |  |  | ELIZABETH MCCOWAN  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT Address  |  |   |  |  |  |
| NO   |  | 578-42-0898  |  | E. Mullings Rr. Md. Masonic Home   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>White Coronary artery occlusion</u>   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |
| (b) <u>Arteriosclerotic heart disease</u>  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |
| (c) <u>3. osteoporosis</u>   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |  |  |
| 4301   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1965, to August 18 1968, that (I) (we) last saw the deceased alive on August 9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 5-A M. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |  |   |  |  |  |
| James H. Hamed MD  |  | 8/18/68  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| JAMES H. HAMED   |  | MASONIC HOME, COCKEYSVILLE, MD   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| BURIAL   |  | Aug 20, 1968   |  | Loudon PARK  |  | BALTIMORE   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| W. Cook-Brooks Towson  |  | 1030 York Rd Towson Md 21204   |  | AUG 20 1968  |  | Charles Judge   |  |  |  |

MEDICAL CERTIFICATION

RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any other event, within 72 hours after death.

VR A15 14  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |  |  |                                      |                        |                                  |  |
|--|--|---|--|--|--|--|--|--------------------------------------|------------------------|----------------------------------|--|
| 11272  |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| 11279  |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| 1. DECEASED-NAME (Type or print) <sup>First Middle Last</sup> <i>Edgar Franklin White</i>  |  |   |  |  |  | 2a. DATE OF DEATH <sup>Month Day Year</sup> <i>August 2 1968</i>               |  |                                      | 2b. HOUR <i>8:30</i> M |                                  |  |
| 3. SEX <i>Male</i>   |  | 4. RACE <i>Caucasian</i>  |  | 5. DATE OF BIRTH <i>3/29/15</i>  |  | 6. AGE (In years lost birthday) <i>53</i> YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS          |                        | IF UNDER 1 YEAR HOURS MIN        |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.  |  |                                      |                        |                                  |  |
| 10. CITY OR TOWN OF DEATH <i>Cummings Pl. Hs. Md</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rosewood State Hospital</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>                                  |  |                                      |                        |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER <i>1526 Shindler Ave</i>                                |  |                                      |                        |                                  |  |
| 14. FATHER'S NAME <sup>First Middle Last</sup> <i>Edgar Franklin White</i>   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME <sup>First Middle Last</sup> <i>Lilly M Bernhardt</i> |  |                                      |                        |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>None</i>  |  | 17. INFORMANT <i>Rosewood Records</i>  |  | Address <i>Cummings Pl. Hs. Md</i>   |  |                                      |                        |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction, massive</i>  |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>institutionalized 30 yrs due Post infectious encephalopathy</i>   |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |  |                                      |                        |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                                      |                        |                                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                      |                        |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 21, 1938</i> , to <i>Aug 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |                                      |                        |                                  |  |
| 22b. SIGNATURE <i>Richard A. Jones</i>   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>   |  | STAFF PHYS. <input type="checkbox"/> |                        | 22c. DATE SIGNED <i>3 Aug 68</i> |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Dr. Richard A. Jones</i>   |  | 22e. ADDRESS <i>Rosewood State Hospital</i>   |  |  |  |  |  |                                      |                        |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 23b. DATE <i>8/6/1968</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>  |  | 23d. LOCATION (City or Town) <i>Baltimore</i>                                  |  | (County) <i>Md.</i>                  |                        | (State)                          |  |
| 24. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, Md. 21212</i>  |  | 25a. REC'D BY REGISTRAR <i>AUG 5 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>  |  |  |  |                                      |                        |                                  |  |

MEDICAL CERTIFICATION

11310

STATE OF OHIO

11310

*[Faint, illegible handwriting]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Alice Middle MOODY Last Whitlock |   |  | 2a. DATE OF DEATH<br>Month August Day 8, Year 1968                                   |  | 2b. HOUR<br>7:00 p. M.  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>March 12, 1900  |  | 6. AGE (In years<br>last birthday)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>housework   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Govans   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>9 Murdock Road                      |  |
| 14. FATHER'S NAME First Middle Last<br>William Moody   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Alice Pastorfield   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.<br>213-03-2156A  |  | 17. INFORMANT Address<br>Records: SPRING GROVE STATE HOSPITAL   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |  |  |   |  |
| PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic, Cardiovascular Heart Dis. 3 days.  |  |   |  |   |  |  |  |   |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Generalized, Senile. 10 yrs.   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 9, 1968, to Aug. 8, 1968, that (b) (we) last saw the deceased alive on Aug. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i>  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>8-9-68   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.   |  |   |  | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br>BURIAL   |  | 23b. DATE<br>Aug. 12, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road<br>Towson, Maryland 21204   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 12 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                   |  |   |  |

MEDICAL CERTIFICATION

UNCLASSIFIED

DATE: 12-12-1978

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

EXCEPT WHERE SHOWN OTHERWISE



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. The 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11273 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11281

|  |                  |   |                       |   |  |  |  |
|--|------------------|---|-----------------------|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Bertha</b>  |                  | First <b>Map</b> Middle <b>Williams</b> Last  |                       | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <b>Aug</b> Day <b>3</b> Year <b>68</b>   |  | 2b. HOUR <b>11:00 P.M.</b>   |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>Jan. 17, 1888</b>   | 6. AGE <b>86</b> YRS. | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign) <b>Md., Union Bridge</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>Carver G. U.S.A.</b>  |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. COUNTY OF DEATH <b>Baltimore, 21227</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Rosemont</b>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1227-3624-Baltimore St.</b> |                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                  | 13b. COUNTY <b>Balto</b>  |                       | 13c. CITY OR TOWN <b>Rosemont</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME <b>Samuel</b>  |                  | First <b>Yungling</b> Middle <b>Parah</b> Last  |                       | 15. MOTHER'S MAIDEN NAME <b>Parah</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>                  |  |
| 16a. SOCIAL SECURITY NO. <b>105-09-0227</b>  |                  | 16b. SOCIAL SECURITY NO. <b>220-48-5403</b>   |                       | 17. INFORMANT <b>Elizabeth M. Mosberger</b>   |  | ADDRESS <b>same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congest ive Hart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4129</b><br>(b) <b>Atherosclerotic Cardiovascular dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 yrs.</b>                           |                  |   |                       |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b>                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |                  |   |                       |   |  |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                       |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year <b>Aug. 3, 1968</b>  |                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                  |   |                       |   |  |  |  |
| ACTUAL SIGNATURE <b>J. Nelson McKay</b>  |                  | EXAMINER'S NAME (Type) <b>J. Nelson McKay, M.D.</b>   |                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED <b>Aug. 4, 1968</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                  | 23b. DATE <b>Aug. 7, 1968</b>   |                       | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>                            |  |
| 24. FUNERAL DIRECTOR <b>Curtis E. Evans</b>  |                  | ADDRESS <b>1400 S. Charles</b>  |                       | 25a. REC'D. BY REGISTRAR <b>AUG 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

1881

APR 3 - 1881

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1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11274

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11282

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILBERT</b> First <b>-</b> Middle <b>WILLIAMS, JR.</b> Last  |  |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>25</b> Year <b>68</b>              |   |  | 2b. HOUR<br><b>7:10 PM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br><b>6/10/27</b>  |  | 6. AGE (In years last birthday)<br><b>41</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRUCKING</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>211 S. Penn Street</b>                    |  |
| 14. FATHER'S NAME First <b>WILBERT</b> Middle <b>WILLIAMS, SR.</b> Last   |  |   | 15. MOTHER'S MAIDEN NAME First <b>MARGARET</b> Middle <b>MN: UNKNOWN</b> Last |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>PL 28 220 22 50 21</b>   |   | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA RIGHT LUNG</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BRONCHOPNEUMONIA LEFT LUNG</b> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/1/68</b> , 19____, to <b>8/25/68</b> , 19____, that <del>he</del> (we) last saw the deceased alive on <b>8/25/68</b> , 19____, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I</del> we) (did) (did not) view the body after death.                                       |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>George C. McElpatrick</i>  |  | DEGREE<br><b>GEORGE C. MC ELPATRICK, M. D.</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/26/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GEORGE C. MC ELPATRICK, M. D.</b>  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-29-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Elmer O. Wilson</i>  |  | WILSON FUNERAL HOME<br>1000 BRANTLEY AVE.   |   | 25a. REC'D BY REGISTRAR<br><b>AUG 28 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |

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## CERTIFICATE OF DEATH

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|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CARROLL</b>  |  |  | First Middle Last<br><b>JAMES WILLS</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>23</b> Year <b>68</b>  |  |  | 2b. HOUR<br><b>11:30</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>CAUCASIAN</b>   |  |  | 5. DATE OF BIRTH<br><b>6/23/1907</b>  |  |  | 6. AGE (In years last birthday)<br><b>61</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Service Foreman</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Co.</b>                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>213 Lochnell Road</b>  |  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Frederick Wills</b>                            |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Margaret Kuper</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)<br><b>None</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-0615</b>  |  |  | 17. INFORMANT<br><b>Family records</b>  |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PERFORATED ACUTE AND CHRONIC CHOLECYSTITIS AND</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POST-OPERATIVE INFECTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1538</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/10/68</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF COLON</b>               |  |  | 20a. AUTOPSY?<br>Y <input checked="" type="checkbox"/> N <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                           |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> , 19 <b>68</b> , to <b>8/23/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R. Breiteecher</b>   |  |  | DEGREE<br><b>R. BREITEECHER, M.D.</b>   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22c. DATE SIGNED<br><b>08-23-68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>R. BREITEECHER, M.D.</b>   |  |  | 22e. ADDRESS<br><b>6701 N CHARLES ST</b>  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Aug. 26, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville, Maryland</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burrell Sons, Towson, Md.</b>   |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 27 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11276   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                        |  |  |                  |  |  |  |  | 11284     |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|------------------------|--|--|------------------|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |                        |  |  |                  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Harry Wisner   |  |  |  |  |  |  |  |  |  | 8 Month 15 Day 68 Year  |  |                        |  |  |                  |  |  |  |  | 2:00 P.M. |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |   |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS. |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| male  |  |  | White  |  |  | 6-8-1880   |  |  | 38 YRS.  |   |  | MONTHS 2 DAYS 7        |  |  | HOURS MIN.       |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Md.   |  |  | U.S.A.   |  |  |  |  |  | Baltimore Md.  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Baltimore #28   |  |  | Caton Lodge N/A  |  |  | Steam Fitter   |  |  | Construction   |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET AND NUMBER |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Md.   |  |  | Baltimore  |  |  | Baltimore  |  |  | YES  |   |  | 1803 Summit Ave 27     |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Unknown   |  |  |  |  | Unknown  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  | 217-01-6582A   |  |  |  |  | Jane Hager  |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH CAUSED BY:  |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 4129 IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure   |  |  |  |  |  |  |  |  |  | 1 Year  |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4221   |  |  |  |  |  |  |  |  |  | (b) A.S.C.V.D.  |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | (c) Generalized Arteriosclerosis  |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Ferropeic Anemia - Hemiplegia   |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No.   |  |  | City or Town   |   |  | County                 |  |  | State            |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-28-1967, to 8-15-1968, that (I) (we) last saw the deceased alive on 8-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED  |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Cesar Valle Cervero   |  |  |  |  |  |  |  |  |  | 8-15-68   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| CESAR VALLE CAVERO  |  |  |  |  | 8629 Liberty Rd  |  |  |  |  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Burial  |  |  | 8/19/68  |  |  | Western Cemetery   |  |  | Baltimore, Maryland  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |
| Ambrose Inc 1329 Sulphur Sp. Rd   |  |  |  |  |  | DATE AUG 21 1968   |  |  | J Charles Judge  |   |  |                        |  |  |                  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| Name of deceased       |  | Date of birth          |  |
| Sex                    |  | Race                   |  |
| Marital status         |  | Occupation             |  |
| Cause of death         |  | Place of death         |  |
| Time of death          |  | Signature of physician |  |
| Signature of registrar |  | Signature of informant |  |
| Date of death          |  | Date of registration   |  |



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or Print)  |  | First Middle Last<br>SAMUEL <del>RA</del> WITMAN   |  |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED  |  | 2b. HOUR  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>8-22-1883  |  | 6. AGE (In years last birthday)<br>85 YRS.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>Aug 22 1968 19                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Russia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED |  | 9. COUNTY OF DEATH<br>Balto Co.   |  | 2d. HOUR<br>M   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Balto Co Gen Hosp. |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Compositor |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Printing                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>New Jersey  |  | 13b. CITY<br>Passaic   |  | 13c. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>91 Howard Ave   |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Moses Witman   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ethel ? ?   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Unknown   |  | 16b. SOCIAL SECURITY NO.<br>135-10-5604  |  | 17. INFORMANT<br>Harold Witman - 4124 Raleigh Rd   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4109 IMMEDIATE CAUSE (a) Myocardial (ischemic) infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic CHD<br>DUE TO, OR AS A CONSEQUENCE OF (c) 15 yrs  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>-                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201 Fracture of right hip  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>8/7/68   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fracture of hip                                |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. Aug 6 19 68                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)<br>Fell in bath room (Fainted)                           |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)<br>Home of ?         |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>J. Nelson McKay, MD.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED<br>Aug 22, 1968  |  |
| EXAMINER'S NAME (Type)   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | ADDRESS (Street, city, town, or county)   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>8/22/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bnai Israel  |  | 23d. LOCATION (City or Town) (County) (State)<br>Newark, N.J.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Sol Levinsen - Bros Inc - Balto Md   |  | 6010 Resistingtown Rd.   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 27 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |

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RECORDS OF THE DEPARTMENT OF THE ARMY



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11286

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Baby Boy Wolfe</b>  |  |  | 2a. DATE OF DEATH<br>8 Month 4 Day 68 Year |   |  | 2b. HOUR<br>10:30   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>8-4-68</b>   |  | 6. AGE (In years<br>last birthday)<br>— YRS.                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>607 Delaware Ave.</b>                      |  |  |  |
| 14. FATHER'S NAME<br>First <b>Kenneth</b> Middle <b>Wolfe</b> Last <b>Wolfe</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Linda</b> Middle <b>Lee</b> Last <b>Sheehan</b>                       |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>776x</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <b>8/4/</b> , 19 <b>68</b> , to <b>8/4/</b> , 19 <b>68</b> , that (A) (we) last<br>saw the deceased alive on <b>8/4/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jose A. Aguto</b>   |  | 22c. DATE SIGNED<br><b>8/5/68</b>  |  | 22d. PHYSICIAN'S<br>NAME (Type) <b>Jose A. Aguto, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>7620 York Rd. 21204</b>                       |  |
| 23a. BURIAL CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><b>8-7-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>W. Med. School</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 9 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |           |  |  |  |   |   |  |  |  |
|---|-----------|--|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |           |  |  |  |   |   |  |  |  |
| 11279 CERTIFICATE OF DEATH 11287  |           |  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |           |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |
| Calvin Randolph Storrell  |           |  |  |  |   | August 2, 1968  |  |  | 5:30 P. M.                                   |
| 3. SEX  | 4. RACE   |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)   |  | 7. IF UNDER 1 YEAR   |  |
| Male  | Caucasian |  | 10-10-61   |  |   | 66 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |           | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |
| Maryland  |           | U.S.A.   |  |  |   | Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Cwings Mills, Md  |           |  | Rosewood State Hospital  |  |   | None  |  |  | None   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |           |  | 13b. COUNTY  |  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS  | 13e. STREET AND NUMBER                       |
| Maryland  |           |  | St. Marys Co. Mechanicsville   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | Rt. 2 Mechanicsville Md  |  |
| 14. FATHER'S NAME   |           |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |  |  |
| First Middle Last   |           |  | First Middle Last  |  |   |   |  |  |  |
| Gerald Storrell   |           |  | Spilma Lee   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |           |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |  |  |  |
| No  |           |  | None   |  |   | Rosewood Records. Cwings Mills Md   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |           |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |           |  |  |  |   |   |  |  |  |
| IMMEDIATE CAUSE (a) 746.9 Cardiac failure   |           |  |  |  |   |   |  |  | 15 minutes.                                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Congenital heart disease   |           |  |  |  |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7545   |           |  |  |  |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |           |  |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |           |  |  |  |   |   |  |  |  |
| Multiple congenital anomalies of brain - Microcephaly (congenital) GM. seizure  |           |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |           |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |           | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |  |
|   |           | HOUR A.M. Month Day Year P.M. 19   |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |           | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
|   |           |  |  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-6, 1968, to 8-2, 1968, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |           |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE  |           |  |  | DEGREE   |   | ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |
| ESTEBAN V. DIAZ   |           |  |  | M.D.   |   |   |  | 22c. DATE SIGNED 8-2-68  |  |
| 22d. PHYSICIAN'S NAME (Type)  |           |  |  | 22e. ADDRESS   |   |   |  |  |  |
| ESTEBAN V. DIAZ   |           |  |  | 321-E. BELCREST- BEL-AIR-Md.   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |           | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Removal   |           | Aug. 4, 1968   |  | Turman Cemetery  |   | Willis, Floyd Co. Virginia  |  |  |  |
| 24. FUNERAL DIRECTOR  |           |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| H. J. Edhardt   |           |  |  | Cwings Mills, Md.  |   | DATE AUG 6 1968   |  | J. Charles Judge   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

| 11280  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11288                      |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|------------------|--|--|--|--|-------|--|--|--|--|-----|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR                   |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Katherine W  |  |  |  |  |  |  |  |  |  | Wright   |  |  |  |  |  |  |  |  |  | 8 24 68 849 M              |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR            |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Female   |  |  |  |  | White  |  |  |  |  | 7-3-1891   |  |  |  |  | 77 YRS.  |  |  |  |  | MONTHS                     |  |  |  |  | DAYS             |  |  |  |  | HOURS |  |  |  |  | MIN |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                            |  |  |  |  | Md               |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Pittsburg, Pa.   |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Cockeysville   |  |  |  |  | Bonnie Blint Masonic   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER     |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Md   |  |  |  |  | Howard   |  |  |  |  | Baltimore  |  |  |  |  | YES  |  |  |  |  | 101 Southview Road         |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| John T   |  |  |  |  | EKAS   |  |  |  |  | Leonida Collins  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| No   |  |  |  |  | RR, Retiree  |  |  |  |  | Md - 167485  |  |  |  |  | Masonic Home   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia acute</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 402X DUE TO, OR AS A CONSEQUENCE OF <u>Chronic heart failure</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>arterial hypertension</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| (c) <u>Senile Degeneration</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 443X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 15, 1965, to August 24, 1968, that (I) (we) lost saw the deceased alive on August 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22b. SIGNATURE <u>JAMES H. HANFORD MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 8/24/68   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>JAMES H. HANFORD MD</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <u>MASONIC HOME, MD Cockeysville</u>  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| BURIAL   |  |  |  |  | 8-28-68  |  |  |  |  | LONDON PARK Cem.   |  |  |  |  | BALTO, Md.   |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| WM COOK-BROOKS WEST INC. 6212 BALTO. NAT'L PIKE.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | AUG 30 1968  |  |  |  |  | J. Charles Judge           |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11281

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 11 Film 6402 21133  
**CERTIFICATE OF DEATH**

11289

|  |  |  |  |   |  |  |                                   |   |  |
|--|--|--|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>STEVEN TIMOTHY WYATT</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>Aug</b> Day <b>4</b> Year <b>68</b>                          |   |  | 2b. HOUR<br><b>4:30</b> AM   |                                   |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>Mar 1, 1957</b>  |  | 6. AGE (In years last birthday)<br><b>11</b> YRS.                          |                                   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                             |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>USA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO</b>   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore Co. Gen. Hos.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |  | 13b. CITY OR TOWN<br><b>Balto</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>6709 Covehill Rd</b>                          |                                   |   |  |
| 14. FATHER'S NAME<br>First <b>George</b> Middle <b>C</b> Last <b>Wyatt</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Nina</b> Middle <b>Lean</b> Last <b>Niederwiesing</b> |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>60</b>  |  | 17. INFORMANT<br><b>Father</b>  |  | Address  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Upper Respiratory Tract Infection</b><br><b>465X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>475X Cerebral Palsy</b>  |  |  |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/30, 1968</b> , to <b>8/1, 1968</b> , that (I) (we) lost saw the deceased alive on <b>8/1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Ronald Berger</b>   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>8/4/68</b>  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RONALD BERGER, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>7501 LIBERTY RD.</b>   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug. 6, 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville Maryland</b> |                                   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Funeral Home 8728 Liberty Rd.</b>  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 9 1968</b>                               |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>            |  |

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*[Faint, mostly illegible text and markings covering the main body of the page. Some faint words like "ORDER" and "RECEIVED" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |  |   |  |   |
|---|---|---|---|--|---|--|---|
| 11282   |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |  |   | 11290  |   |
| 1. DECEASED-NAME<br>(Type or print) <b>BLANCHE</b>  |   | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>9</b> Year <b>1968</b> |  | 2b. HOUR<br><b>10 A M</b>                                     |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br><b>June 4, 1882</b>   |   |  | 6. AGE (In years last birthday)<br><b>86</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS  | IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summitt Nursing Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Elkridge</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 13e. STREET AND NUMBER<br><b>5709 Old Wash. Rd. 21227</b>                                  |   |  |   |
| 14. FATHER'S NAME<br>First <b>Henry</b> Middle <b>Baker</b> Last  |   | 15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Treherne</b> Last  |   |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Margaret Y. Robbins, 5709 Old Wash. Rd.</b> Address <b>Elkridge 27</b> |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOSTATIC pneumonia</b><br><b>514X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydrated age</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart failure</b> |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>522X None</b>  |   |   |   |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)            |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/29, 1968</b> , to <b>8/9, 1968</b> , that (I) (we) last saw the deceased alive on <b>8/8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |  |   |
| 22b. SIGNATURE<br><b>Cliff Patliff, Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   |   |   | 22c. DATE SIGNED<br><b>8/9/68</b>  |   |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CLIFF PATLIFF, JR.</b>   |   | 22e. ADDRESS<br><b>4605 Edmondson Ave</b>   |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>8-12-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                          |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick Ave., Balto. 21229</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave., 21229</b>  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>AUG 12 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Judge</b>                                      |   |

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Handwritten notes and signatures on lined paper, including a signature at the bottom left.